Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ <sup>Day</sup> 2010 Perle Oakes Branch 4 6:18 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Sept. 9 Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs Funeral 9. Birthplace (State or Foreign 1 M 2 X F Months Davs Hours Min. Year) 1912 224-14-7356 Director 97 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Spencerville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2031 Avoca Lane 20868 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 X Widowed 4 Divorced Specity: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 9 John Samuel Oakes Viola Eanes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Fox/Daughter 2031 Avoca Lane, P.O. Box 215, Spencerville, MD 2086\$ 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place) 1 Buriat 2 Cremation 3 K Removal from State June Mountain View Cemetery 4 Donation 5 Other (Specify) Danville, VA Signature of Funeral Service 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Medical disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregr 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant Month Day Year Pregnant at time of death 5 Other (specify) Yes a  $\square$  Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sh autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? thin 24 hours after death.

the Funeral Director: An impleted filled in by the fu 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only on Signa 2gb. erson who completed cause of death (Item 23a) (Type, Print)

State Registrar Month, Day, Year)

9

2010

Registrar's Signature

		ForState	State o	of Maryla	-	irtment of I tificate of I		Mental Hy	0.0	10	10503
		Registrar  1. Decedent's Name (First, Middle	e, Last)		Cer	incate or i	Jeani	2. Date of De	Reg. No.	1 13	3. Time of Death
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Examin		4a. Facility Name (if not institution	, give street and nun	nber)		4b. City, Town, o	r Location of Dea	ath	4c. Count	of Death	
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Funeral Director		5. Social Security Number 186-24-9860	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs.	81 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, <sup>Year)</sup> 29, 1929	9. Birth	place (State or Foreign htry) MD
T OM		Usual Residence of Decedent  10a. State 10b. County		T <sub>40</sub> , o							
iryland I-f sh ied a	Director			10c. C	ity, Town or Loc						10d. Inside City Limits 1 X Yes 2 □ No
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Inc., INCL YIGHTU ZIZIOOOO  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natura", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	10 B	17. Father's Name (First, Middle, L Andy H. Schrie	,					ame <i>(First, Middle</i> trice En	*	e)	
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ge 1 an stoff He or other		20a. Method of Disposition  1 X Burial 2 Cremation			Place of Dispos	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	own, State
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permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	Licensee			Name and Addre					750_0368
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death or	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 Live	Birth 2 Fe	tal death 3 🗌	Ectopic pregnant Other (specify) _	су		1	ate of deliv onth	Day Year
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Nysician hysician his certifi I director	10 B	examinor? 1  Yes 2  No	Hospital:	Inpatient 2	BR/Outpatien	t 3 🗆 DOA Oth	ner: 4  Nursing	Home 5 Res	idence 6 🗀 Oth	ner (Specif	v)
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		g Physician: To the t Examiner: On the ba								ed. ause(s) and manner stated.
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		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type, P	rint)	1+	_	, Itaj.	ersto	wn, co
Sta	to	Idu 2 Td W 31. Date filed (Month, Day, Year)	1. 91to)	Registrar's Sign	[9,00	1 orchia	ic les	race Re	4 0	211	12
Sta Registr		JUN 2	2 2010	Perens	1. 4	bartel					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#31 per HD State of Marylal state Registrar6/4/2010 AACO HEALTH DEPT CMH Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2010 Richard Creek 8:15 a M 1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1 Meade Circle Road
| Security Number | 6. Sex | 7. Ag Arunde1 Severn Anne | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Unner 29 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 1930 Maryland 215-28-2757 Director 79 Yrs Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at by Funeral Director 1X Yes 2 No Severn Maryland Anne Arundel 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1711 Meade Circle Road 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th 0 Domestic Private Family other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. and Mental Fisherked o ပ Joseph Creek Mary Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Creek (Neice) 568 Glen Ct. Glen Burnie, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chews Church Ceme. 6/7/10 Owensville, Md. Signature of Funeral Service Licensee Name and Address of Facility M. Reese & Sons Mortuary d. P21401 21 West St. Annapolis, Md. P21401 Zar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical rdies anes Due to (or as a consequence of): **Examiner** Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events g physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last law requires that the death certificate be Box 68760 as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No the 9 Unknown P.O. þ To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

#### State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Physician/ Ε. Calhoun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ROGIONAL SOISHIFY TANINSULA Center If Under Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 04-27-1922 1 🗆 M 2 🗶 F Min 217-42-6152 88 **Director** Usual Residence of Decedent show 10c. City, Town or Location notified at Director 28a-f MD Somerset Westover 10e. Street and Number ō 10f. Zip Code must be 23a Funeral 31416 Rehobeth Road 21871 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No Examiner ö þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene. Furt. If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Examiliary or other traumatic event, the Medical Examiliary. Maryland 21215-0036 Yes, 1 ☐ Yes 2 X No Specify: Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hurbert Worth Effie Worth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Hall Dirickson/daughter 200 Creekside Drive, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rehobeth Presbyterian 06/03/2010 Rehobeth, Maryland ignature of Funeral/Serv .22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician/ EPTIC (hoc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ongestive Secuentially list or neltillos Examine if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 1) Vertrentitre Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) signed by the atte in the past 12 months? Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, peen has this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2. Date of Death

Month

Day

4c. County of Death

10g. Citizen of What Country?

USA

HICOMIC

14. Race - American Indian,

Delmarva Hearing Aide

Specify: White

20c. Location - City or Town, State

Princess Anne.

16b. Kind of Business Industry

3. Time of Death

0030

10d. Inside City Limits

Interval Between

Onset and Death

1 Yes 2 No

9. Birthplace (State or Foreign Country) Maryland

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

E. CALLOII

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:45 PM 2010 Medical 4c. County of Death Examiner City, Town, or Location of Death Baltimore NIA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina Funeral 8. Date of Birth 03 Director March 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 🕅 No West River Marvland Anne Arundel 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20778 USA 5147 Chalk Point Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ò 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10th Self Employed Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Everett Call Minnie Stalev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Melissa J. Call/ Wife 5147 Chalk Point Rd., West River, MD 20778 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) njury or Lakemont Cemetery 6/5/10 Davidsonville, MD 21. Signatus Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to manufacture cause. Enter Underlying Cause (Disease or linjury Examine Syndrome sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last physician Alconolic Liver Disease Physician/Medical Box 68760 as the b IF FEMALE for use a If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 2 🗌 No 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require, within 24 hours after death.

To the Funeral Director. After this certificate has been sit completed filled in by the funeral director, page 2 should I 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{\tint{\text{\tint{\text{\tinit}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texiext{\texi}\text{\text{\text{\text{\text{\texi}\text{\text{\texitile}}\text{\text{\text{\text{\texitile}}\text{\text{\texi}}\tinttt{\text{\ti}\text{\text{\texitile}}}\tinttilef{\text{\texitile{\text{\texi} 2 **N**O မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Baitimore DOOL 2010

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:30 PM Gloria 2010 Jean Carrick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbu Coasta 07 Hospice Nicomi CO 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min. (Month, Day, 215-38-1454 Yrs. Director 67 3-194 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2 No MD Wicomico Salisbury 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 6116 Ruth Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown 2 Robert Lee Adams Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Ray Carrick, Sr.-Husband 6116 Ruth Street, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 6-8-2010 Salisbury, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home Heu 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ nd disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Month Day signed by the a Id be detached for g 🗌 Unknown P.O. Part II. **Othe**r s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 2 🗶 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) 12 2 X No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work n 24 hours after death.

e Funeral Director: Afte leted filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 06-05-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

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		State Registrar			Cei	tifica	e of De	eath		Reg. N	<u>6.20</u>		1950
Physician Medica	/	Decedent's Name (First, Middle     ANTHONY CFE)	e, <i>Last)</i> RARD CARR	TEMM A					2. Date of D Month MAY 3	D	ay 2010	Year	3. Time of Death 5:00 P M
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permit. Page 1 and 2 should e filed within 72 hours Department of Health and Mr ntal Hygiene. Important if item 27 is mar ed other than "natur any injury or other traumati event, the Medical once.	-1	Flavia Carrett							ural Route Numb ace. Un				ck, MD2170
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Page nent o nt: If ry or		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (		State	cemetery, crer cauffer	natory or	other place)		/2010			-	Maryland
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Physician: The law this certificate has all director, page 2:		examiner? 1  Yes 2 No	Hospital:	npatient 2	ER/Outpatier	nt 3 🗆 🖸	OA Other:	4 🗆 Nursing	Home 5 Res	sidence	6 □ Othe	er (Specify)	
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he Hospita in 24 hours he Funeral ipleted fille		(Check 2 $\square$ Medical E	xaminer: On the basi Nurse Practioner: T	s of examinatio	on and/or inves	tigation, in	my opinion,	death occurred	l at the time, date	and plac	e, and due	to the cau	se(s) and manner state
Voithir comp		29b. Signature and title of certific		0 (10 000; 0	, Milemodge,		c. License n		iace, and due to			(Month, E	-
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		30. Name and address of person				Print)							
Stiurt		Ghulam Abbas,				t, F	reder	ick, MD	21701				
State Registrar		31. Date filed (Month, Day, Year)	32. Re	egistnar's Signa	ature	6.	11						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiano /	•	irtment of H tificate of D		na ivien		_	0010	10500
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			FREDERICK ME 5. Social Security Number		TAL e (In yrs. last b	irthdoul	FREDERIC	K If Under 24	I Hrs. To r	Date of Birt		FREDERIC	
V.	Funeral Director		219-36-5647 Usual Residence of Decedent	1 X M 2 □ F	68	Yrs.	Months Days			Month 31		941 Mar	thplace (State or Foreign y Tand
	and show dat	ρ	10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits
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21215-0036	s flied within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 ☐ Widowed 4 ☑ Divorced	ied 12. Was Decedent E Armed Forces? 1 🛣 Yes 2 🗍 If Yes, Give Year or Dates.	No	lf 4	/as Decedent of His Yes, specify Cubar	n, Mexican, P	n? (Specify ) Puerto Ricar	Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			e, etc.
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€, ₹	1 and 2 should be if Health and Men item 27 is marke other traumatic		Amy Farozic / I	Daughter			Davis St	., Wil	lards	, MD			
Baltimore, Maryland	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (S	pecify)	ceme	tery, crem	sition (Name of atory or other place Cremato	Jı	une 5 2010	,		derick,	Town, State Maryland
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P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  Of the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 1 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)					23d. Date of del Month	ivery Day Year
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Division of Vital Records,	he law require tte has been si age 2 should b	Completed by							_	24a. Was a autop perfor	sy	prior to death?	opsy findings available completion of cause of
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o uo	eath. or: After the funer	Certificate;	27. Manner of Death  1   Natural  2   Accident  3   Suicide  Could r	ation		. Time of injury	28c. Injury work? M 1 🗆 Y		- 1	Describe h	ow inju	ry occurred	
Divis	tal or Att rs after d al Direct ed in by		4 Homicide determi			farm, stree	et, factory, office			ocation (S City or Town		nd Number or Rur e)	al Route Number,
	To the Hospital or Attending Physician: The kantibute At hours after death.  Of the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 L Medical E	Physician: To the best of r kaminer: On the basis of ex Nurse Practioner: To the b	amination and	or investig	gation, in my opinior	, death occur	rred at the ti	me, date ar	nd place	e, and due to the o	ause(s) and manner stated.
	To t To t		29b. Signature and title of certifier		910		29c. License			2	29d. Da	ate signed (Month	, Day, Year)
	)		* Larik		110		MDD	6544	3			5/30	110
_5	TIVA		30. Name and address of person v	lova 400	DWI			deric	ck, r	uD 3	170		,
	Stat Registra	.С	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature		parked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martine Anne Campagnone 2010 5. June 9:10 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Min. (Month, Day, Year) 1958 New York **Director** 216-80-7842 51 Dec. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Maryland | Montgomery Gaithersburg 1 Yes 2 No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9321 Warfield Road 20882 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 K Never Married 2 Married Completed by 21215-0036 If Yes Give 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natui jury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Campagnone Anne Marie Sansone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mari-Josette Campagnone (Sister) 21726 Mobley Farm Dr., Laytonsville, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of v 14, 20c. Location - City or Town, State carreign repution (varies of carreign repution)
National Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Arlington, Virginia Signature of Funer 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part Fifte the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Paysician RESPIRATORY FAILURE Medical Due to (or as a consequence of) Examiner SEPSIS CANDIDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or Examir ADULT RESPIRATORY DISTRESS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit SYNDROME Cause (Disease or iinjury I WEEK that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical CHOLECYSTITIS MONTH IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MICROCEPHALY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 🛚 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760

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CAMPAGNONE

State Registrar

(Check only one 29b. Signature and title of cer

JOHN

R.

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

MD

MELNICK

0 9 2010

911 RUSSELL

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

GAITHERSBURG

29d. Date signed (Month, Day, Year) June 6,2010

20879

MARYLAND

29c. License number

AVE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 5, Nellie F. Class 2010 9:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18003 Matney Road, Apt. 110 Germantown Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 ☐ M 2 🛣 F Days Hours Min Ohio 279-18-3472 91 Yrs Director Dec. Usual Residence of Decedent shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery Germantown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18003 Matney Road, Apt. 110 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: 3 K Widowed 4 Divorced Specify: Completed Year or Dates White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Ferrari Mae Hessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Toni DeCesare Woods (Niece) 20149 Laurel Hill Way, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of June 14. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery crematory or other place) 4 Donation 5 Other (Specify) Chardon, Ohio 2010 Cemetery Signature of Euneral Sen 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ )re397 Cano disease or condition Cars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Panneral Director: After this certificate has been signed by the attending physicia. Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Pregnant at time of death 5 Other (specify) signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State

10

30. Name and address of perso

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Type,

MC

Registrar's Signature

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Gaithersburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Lawrence S. Cohan June A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>Suburban Hospital</u> <u>Bethesda</u> Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Oklahoma Director 441-34-4556 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Director 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Potomac MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11808 Charen Lane 20854 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No 1956—
If Yes, Give 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 1960 Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) <u>Scientist</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Albert</u> Cohan Rose Luskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara Cohan / Wife</u> 1808 Charen Ln. Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗌 Burial 2 💢 Cremation 3 💢 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/05/2010 National Crematory Falls Church, VA Signature of Funeral S Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville, MD 20852 Licensee B1ake Kurt Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Small Bowel Ischemia Medical resulting in death) Due to (or as a consequence of) Examiner High Grade Bowel Obstruction Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ certificate has been signed by the atte irector, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed **Amylodosis** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No al or Attending Physician: s after death. I Director: After this certifica Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 1 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit of certifier 29c. License number SUDARSHAW SUT 6 2/10 D65312

State Registrar

Cohan

8600 Old Georgetown Rd. Bethesda MD, 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Sudarshan Siva M.D.</u>

JUN 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Millard Wallace Dashiell 2010 01:26 A M Medical 4a. Facility Name (If not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Hospice at the lisbun NICOMICO If Under 1 Year If Unde **Funeral** Sex. 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 03-15-1924 219-07-4391 86 **Director** Maryland Usual Residence of Decedent death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32093 Dublin Road 21853 USA "natural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1942-52 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none Police Officer Dept. Natural Resources other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental bis is marked o ဂ္ Millard Dashiell Ethel Dashiell or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Dashiell/wife 32093 Dublin Road, Princess Anne, MD 21853 Important: If item 27 any injury or other tra of Health timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Andrews Episcopal 06/06/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Princess Anne, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave. M00295 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and Death Physician METASTATIC LUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes 1 ☐ Yes ∠L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 2 Yes the funeral director, Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICA ၉ Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending / Accident 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Control of the basis of my knowledge. South commed at the time, date and place, and out to the cause(s) and in order as elected. 29a. Certifier (Check To the I within 2 only one 29b. Signature a nd title of certifie 29d. Date signed (Month, Day, Year) 6/3/10 10058410 5 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huggs BO P WD 21802 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maurice Desa			Registrar	tate of Maryla	and / Dep C	partment o e <i>rtificate d</i>	of Health of Death	and Me	ental Hy		•	)   (	1951	
Phys Medical Exa	icia min	n/ ier	Decedent's Name (First, Mid Maurice J     Aa. Facility Name (if not institut)	ohn Desaut						2. Date of Dea Month June 6, 2	ath Day Y	'ear	3. Time of Death 1137 hrs	
Funer	·al	Į	907 Pleasant Valley  5. Social Security Number		_		4b. City, Town	ster			4c. Count Carroll			
Direct			213–82–1642 Usual Residence of Decedent	1 M 2 F	7. Age (in yrs	i. last birthday) Yr	If Under 1 Months If	Year If Un Days Hou	der 24Hrs. Irs Min.		th(MM/DD/YY) 3, 1959	Forei	rthplace (State or gn yrband	
Maryland	nce.	ō	10a. State 10b. County	rroll	10c. Cit	ty, Town or Loca	tion	West	minst	er			10d. Inside City Limits	
th the Mary		II Director	10e. Street and Number 907 Pleasant V	alley Road	i		10f. Zip Cod		1158	1	0g. Citizen of V	Vhat Cou	ntry?	
r death wi	must be	by runeral		arried Armed Fo	2 X No	1 []	- 6.2	ban, Mexica No s <i>pecif</i> y	n, Puerto R ⁄:	tican, etc.)		te, etc. wh i	ican Indian, Black,	
nore, MD 21215-0036  ***gas 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.  "The firm 27 is marked other than "natural".	omploted ex	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-		during m	nt's Usual Occur ost of working I ation El	nginee	r use retire P	d)	Ī	oil c		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	To Bo	N I	William A. Do	esautels.	Sr.	10h Mailine	0.44	Ba	ırbara	ame (First, Middle, Maiden Surname)  Para Cavin  or Rural Route Number, City or Town, State, Zip Code)				
e, MD  I and 2 sho Health and item 27 is		+	W1111am A. Desa	autels, Sr	20b	907 I	Pleasant	t Vall	.ey Ro	pad, We	ber, City or Tov stminst 20c. Location	er,	MD 21158	
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite	111		1 Burial 2 Cremation 4 Donation 5 Other Sp 2 Signature of Funeral Service	ecify:	m State	arroll (	er place)	ry		2010	Winf	ield	l, MD	
Physiciar	1	12	3a. Part I. Enter the disease, or	22. Name and Address of Facility Myers—Durboraw Funer 91 Willis Street, Westminster, MD 21 failure. List only one cause on each line.										
/Medica Examine		Ь	mmediate Cause (Final disease or condition resulting in death)	a. Chronic Alco	holism witl	h Cirrhosis o							Approximate Interval Between Onset and Death	
	Examiner	8 11 0 0	Sequentially list conditions, fany, leading to immediate cure. Enter Underlying Cause Disease or injury that initiated	b.  Due to (or as a c	onsequence of	f):						- 11		
50, se be executed ysician and burial - transit	edical Exa	è	vents resulting in death) Last  UNPENDED	Due to (or as a co	onsequence of	f):						1		
8760, ificate be ex g physician s the burial	n/Medi	IF 23	FEMALE: b. Was decedent pregnant in the	23c. If yes, ou		nancy					23d. Date of	delivery		
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	1	past 12 months?  Yes 2 No 9 Unkn	own 9 Unknown	t at time of dea	ath -	Ideath 3 er (Specify)	Ectopic	pregnancy		Month	Da	y Year	
S, P.O. E uires that the casigned by the defeached	ρ		art II. Other significant conditio	ns contributing to de	eath but not re	sulting in the un	derlying cause	given in Par	t I.				e cause of death?	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Completed								_	24a. Was an autopsy performe	ed? de	ior to con eath?	psy findings available inpletion of cause of	
Vital hysician: this certif	o Be	25	. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2 [	ER/Outpatient		of Death (C		one)	sidence 6	Yes	2 No	
tending Ph death. tor: After t	ation: T		Manner of Death  Natural 5 Pendin		njury :	28b. Time of Inju	ry 28c. Inju	ry at Work? Yes 2 1	28d		v injury occurre	-	cene	
Division  To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 4 29	Suicide 6 Could r Homicide determi	not be ned 28e. Place of (Specify)		ne, farm, street,				or Town, State	∍)		Route Number, City	
To the H within 24 To the F complete	Medical	one	eck brilly outling it trys	sician: To the best of ner:On the basis of ex and manner state	tarrimation and	e, death occurred d/or investigation	i, in my opinion	, death occu	e, and due irred at the	time, date and	place, and due	to the ca	1	
WIL			Name and address of person wh	n ampleted	1)	2-1	29c. License O.C.M				od. Date signed une 7, 2010		Day, Year)	
St			Russell Alexander MD.  Date filed (Month, Day, Year)	Assistant Med	ical Examir	ner 111 P	enn Street,	Baltimore	e, MD 21	201				
Sta Regist	ate		Russell Alexander MD.  Date filed (Month, Day, Year)	Assistant Med		ner 111 P	enn Street,	Baltimore	e, MD 21	201				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 01 2:55 pm James Everett Douglas June. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F Hours April 24 (ear) 932 North Carolina Director 244-42-7619 78 Usual Residence of Decedent 28a-f show 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s sdical Examiner must be notified 1 Yes 2 X No Maryland Prince George's Beltsville 10f. Zip Code 10g. Citizen of What Country? Funeral 12617 Bear Creek Terrace 20705 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc 1 X Yes 2 No 1954 δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced 1956 Black Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Manager U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Van Wyck Douglas Janie Josephine Webb 20852 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Health Craig B. Douglas - Son 11700 Old Georgetown Road, Apt #1511. Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State of Heaven Cem. 06/09/2010 4 Donation 5 Other (Specify) Gate Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. HOH 1070 L1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit and To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician an completed filled in by the funeral director, page 2 should be detached for use as the burial-tro Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Gentifying Nurse Prantioner To the best of my Endwlodge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 15+1 D63579 June 01, 2010 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Maria Taylog, MD, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) JUN 0 8 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thi Dang June 7, 2010 3:30 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1309 Mullins Street Silver Spring Mon topmery if Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2XX F Min. Hours Nov. 20. 1926 577-17-0947 **Director** 83 Vietnam Usual Residence of Decedent 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Mullins Strret 20904 USA Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luan Van Dang Nu Thi Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnny Dang/Son 1309 Mullins Street, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that say ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial Fibrillation Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause Free morely of Cause (Disease or iinjury Due to (or as a consequence of) Exami physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No 5 Other (specify) Month Day Pregnant at time of death signed by the a d be detached for g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis C, Anemia Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 K No 1 Tes **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🗗 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🖳 Natural 5 Pending iours after death.

neral Director: Affilled in by the full 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the

State

B D NUL Registrar

29b. Signature and title of certifier

Huyanh T. Ton, MD 31. Date filed (Month, Day, Year

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D54486

29d. Date signed (Month, Day, Year)

June 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Do	-	artment of H		and M	lental Hy	giene Reg. Ne	-201	0 19516
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Medic	al	William Gregory Doyle  4a. Facility Name (if not institution, give street and number)		Al- City Town on	Location	of Dooth	June		2010	11:00 p M
	Examin	er	Holy Cross Hospital		4b. City, Town, or Silver Spr		Ji Dealii		40	c. County of Deat <b>Mon t</b>	omery
	Funeral Director		5. Social Security Number 551-76-7163  6. Sex 1 ☑ M 2 ☐ F 59 Yr		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Nov • 27		9. Bir Ca 11	thplace (State or Foreign untry) <b>forni</b> a
	od at	_	Usual Residence of Decedent  10a. State 10b. County 10c, City, Town of	or Loc	eation						10d. Inside City Limits
	larylar sa-f sh ified a	Director			pring						1 ★ Yes 2 No
	the M		10e. Street and Number		10f. Zip Code				10g. C	itizen of What Co	ountry?
	n with	Funeral	811 Bonifant Street		20910				USA		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No  If Yes, Give Year or Dates. 1968–71	11	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexicar	i, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Whi	e, etc.
5-0	"natul	plete	15. Decedent's Education 16a. D	leced	ent's Usual Occupa	ation	t of workin	og.	16b. l	Kind of Business	
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0	Hygie Other ent, tl	Be (	17. Father's Name (First, Middle, Last)	rec	tor of Ope:			(First, Middle,	_		Баррогс
ylan	uld be fi I Mental narked natic ev	오	William G. Doyle					ricia M		,	
, Mai	d 2 shore				g Address (Street a K <b>onifant St</b> i						p Code)
Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition  1  Burial 2  Permation 3  Removal from State cemetery, 4  Donation 5  Other (Specify)	crem	sition (Name of natory or other plac n Cremator	e) <b>7</b>	June 201	ate 11 10		ocation - City or	
Balt	permit. Departimport any inj		21. Signature of Fuyeral Selvie Livensee	F£ 50	Name and Address ancis J. Co O Universi	offins by Blv	yFunerd. W.,	ral Home Silver	Inc Spri	ng, MD 20	901
			23a. Part I. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	_							Approximate Interval Between
- 1	Priysician/ Medical	85 A	Immediate Cause (Final disease or condition resulting in death)  Cardiac Arrest								Onset and Death unknown
	Examiner		Due to (or as a consequence of)  Hypertensive Cardie		scular Dise	ease					unknown
		iner	Esquantially list conditions, If any, leading to immediate cause. Enter Underlying								
	scuted and transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of)								3.5 years
0	ate be executed bhysician and the burial-transit	dical E	Due to (or as a consequence or)	•							
3760	ficate g physas the	Nedi	- d								
Division of Vital Records, P.O. Box 687	t the death certificate be executed by the attending physician and trached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnanc Other (specify)	у				23d. Date of de Month	elivery Day Year
Ö.	es that the signed by be detach	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying cause giv	en in Part	I.	23e. Did t	obacco	use contribute to	the cause of death?
- S -	requires t been sign should be	ed by						1 🗆	Yes 2	No 3□P	robably 4 🗆 Unknown
COL	aw req as bee 2 sho	Completed						24a. Was			topsy findings available completion of cause of
æ	The lacate h	Соп							ormed?	death?	s 2 🗆 No
ţa	sician. certifi rector.	Be o	25. Was case referred to medical examiner?  1  Yes 2 X No Hospital:		Out-	ace of Dea					
n of V	ling P. J. After ti unera	cate: To	1	ne of	28c. Injury	4 <u> </u>	2	ne 5 Resi 28d. Describe		6 Other (Spec ry occurred	cify)
visio	I or Attend after death Director; /	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	ı, stre			-	28f. Location ( City or To			ıral Route Number,
۵	spital or At		29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, de	eath c	occured at the time	date and	place and				ated
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Examiner: On the basis of examination and/or i only one) 3 Certifying Nurse Practioner: To the best of my knowled	nvest	igation, in my opinic	n, death o	ccurred at	the time, date :	and place	e, and due to the	cause(s) and manner stated.
•	© 7√		29b. Signature and ittle of certifier  () () as h		29c. License					ate signed (Mont.) <b>/2010</b>	h, Day, Year)
	יווש		30. Name and address of person who completed cause of death (Item 23a) (Ty Peter Basch, MD 660 Pennsylvania Avenue,		rint)		C 2000	)3	2, 3,		
	Stat		_		Ked .	•	7.0	-			
	Registra										

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year elestine 10:05 AM <u> 2010</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges PrinceGeorges Cheverly Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Min. Month, Pay, Year) 45 Director 577-62-8591 Yrs. 64 Sep NCUsual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
 Rant: If Ifem 27 is marked of other than "natural", or items 23a or 28a-f sho tury or orther traumatic event, the Medical Examiner must be notified at jury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges 1 Yes 2 K No Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3855 St. Barnabas Rd. 20746 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Shop Stewardess US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Ross Virtie Driskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3855 St. Barnabas Rd. #T3 20746 Mildred Dennis - Sister Suitland, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or or once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-14-2010 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Landover, MD. Marshall structures fulleral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to onsequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Examiner The law requires that the death certificate be executed physician and s the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 month 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atte Month Year Pregnant at time of death Day Part II. Other gignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 🗌 No Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) ပ္ 1 🗆 Yes No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient After this 28a. Date of injury (Month, Day, Year) 27. Manger of De th Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation filled in by the 24 hours after deat Funeral Director: Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотрыете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the gause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man 29b. Signature and title 29d. Date signed son who completed cause of death (Item 23a) (Type, Print) Atevenis, MO 32. Registr State JUN 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2010 Ronald Franklin Day 5:35 5, Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Ye October 8, Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 X M 2 I 178-24-7383 Director 77 Sunbury, PA October Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Maryland College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5000 Seminole Street 20740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White "natural" 3 Divorced 4 Divorced Completed Year or Dates. 1950–1953 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Law Enforcement Metropolitan Police Officer 12 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ္ Guy Edwin Day, II Edna Kratzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene E. Day / Wife 5000 Seminole Street, College Park, MD 20740 permit. Page 1 and Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salem Lutheran Church Cem. 6/10/2010 Selinsgrove, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? this certificate 1 🗌 Yes 2 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🛚 No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No iniury ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Yea
JUN 0 9 2010

Padma Chirumamilla, 7600 Carroll Avenue, Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-04459 Ronald Eugene Davis

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physiciar		egistrar . Decedent's Name (First, Midd	le,Last)								2.	Date of Deat Month	h Day	Year		3. Time of Death
ledical Examin				Roi	nald E	Eugei	ne D	avis				June 12, 2	010			1322 hrs
	4	a. Facility Name (if not institution	on, give s	treet and numb	er)		4	b. City, Town	, or Lo	ocation of	Death			c. County o		
		Washington County F	lospita	ì				Hagersto	wn					Washing		
Funeral.	5	. Social Security Number	6. Sex	7.	Age (In yrs.	last birth	day)	If Under 1	_	If Under		8. Date of Birt	h (MN	(/DD/YYYY)	9. Birt Cou	hplace (State or Foreign intry)
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MD id 2 sho lith and in 27 is aumati	1	Kandy Lynn Da	vis	(Daug	hter)							irplay	, M	aryla.	nd 2	21733
4 E & B		20a. Method of Disposition		1 .				ition (Name oner place)	f cem	netery,		Date ne 21,	200	. Location -	City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 X Burial 2 Crematic		Removal from	State			irch Ce	eme	tery		010	F	airpl	ay,	Maryland
ti. Partuner	-	4 Donation 5 Other S 21. Signature of Funeral Service		ee		_	Locati	lame and Add	_			212	_			
Baltimore permit. Pages 1 Department of F Important: If injury or other	-1	Tolle /		Marlie	MU	1414					Ave	. Smitl	hsb	urg,	Mary	land 21783
Physician		23a. Part I. Enter the disease, o	or complic	cations that caus	sed the dear	th. Do no										Approximate Interval Between Onset and
Medical	- 1	failure. List only one caus	e on each	<sup>h line.</sup> lypertensive												Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		ue to (or as a co			Cara	Ovasoulai		0000					_	
	- 1	O I'-II . I'-l I'Aliana	b.	,												
	ē	Sequentially list conditions, if any leading to immediate		ue to (or as a co	onsequence	of):										
		cause. Enter Underlying Caus (Disease or injury that initiated	· · -	ue to (or as a co		of):					_					
asi sa	XI.	events resulting in death) Last		ue to (or as a co	onsequence	: 01).										
760, icate be executed physician and the burial - transit			— <u>°.</u>	AMENDED												
D, be es	Medical	UNPENDED											12	3d. Date of	deliver	<u> </u>
76 ficate g phy		IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes, ou			. Fe	tal death	3	Ectopic	pregnan	су	ľ	Month		oay Year
OX 68 ath certificate attending for use as	iai	past 12 months?			t at time of	death 5		her (Specify)					P			
30x death	Physician	1 Yes 2 No 9 U		g Unknow									┸			
, P.O. Box 68 res that the death certif signed by the attending		Part II. Other significant cond	litions o	contributing to d	leath but no	t resulting	g in the u	underlying ca	use gi	iven in Par	rt I.					the cause of death?
P. es that igned	à	CAD										1Ye	s 2	No 3	Prol	oably 4 V Unknown
ds, equir	Completed											24a. Was auto				utopsy findings available completion of cause of
COT law 1 has t	ם				-								orm <u>ed</u>		leath? ✓ Y	es 2 No
Re The ficate	ટ્રા							26	Diago	of Death (	Chack o		<u> </u>	140	<u>V</u>	2 140
Vital Records, hysician: The law requir this certificate has been a director, page 2 should	a	25. Was case referred to medie examiner?		ospital:	patient 2	€ EB/O	utaatiaat						Resi	dence 6	Othe	r:
Physi al dir	의	1 Yes 2 No_		28a. Date of			Time of			ry at Work		28d. Describe	,			
Ing Pl		27. Manner of Death 1 ✓ Natural 5 Pe	. dia .	(Month, D	Day,Year)	200.	11110 01	· ·		res 2	- 1					
ttenc death ctor:	Certification		nding /estigatio	n				1.00				28f Location /	Stree	t and Numb	er or Ri	ural Route Number, City
or A after Direction b	ij		uld not b termined	е	of Injury - A	t nome, ra	arm, stre	et, factory, of	iice bi	unumy, en	·	or Town,			01 01 11	2.0
Spital spital neral	Ö	4 Homicide		1 1 -1 - 27					_		- 1		(-)		. aa atai	end.
e Ho n 24 l ne Fu	ह	29a. Certifier (Check only one) 1 ☐ Certifying Certifying Certifying ✓ Medical E	Physicia	an: To the best	of my knowl examination	edge, de and/or i	ath occu	rred at the tir ation, in my or	ne, da pinion	ate and pla , death oc	ice, and o curred at	the time, date	se(s)	and manner place, and d	lue to th	ne cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical			and manner sta	ted.					e number			_			onth, Day, Year)
	Σ	29b. Signature and title of cert	mer					1	D.C.I					une 14, 2		, ,
		unde_							).U.I	ıvı.⊑.					3.0	
		30. Name and address of pers				em 23a)	D -	04	A:	NA NAD	21204					
		Ana Rubio MD. A	ssistan	t Medical E			Penn (	Street, Ba	timo	ore, MD	21201					
	ate	(1 K) (1 E) A	r)	nan A	istrar's Sign	100	4	Marker								
Regist	10.0	3471 G PI E	Ro Go P	RHHEN / 3	وسالاسلوا فالمالال	1 19	· · · · · · · · · · · · · · · · · · ·	HETULLY COLD								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Year June 07 3:23 P M Stephen Davis Earll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 1611 Highland Drive 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 13,1945 Washington, DC 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number Sex 1 M 2 □ F 217-44-2762 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Tes 2 X No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 1611 Highland Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Ph\_sician/ Medical **Examiner** 

permit. Page 1
Department of
Important: If it
any injury or o

Physician/

Medical

Director

Funeral

by

Completed

Be

**Examiner** 

**Funeral** 

Director

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

oorant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit ed by the page 2 should be has this certificate thin 24 hours after death.

the Funeral Director: After this certifical mpleted filled in by the funeral director, I

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

the မ ₹ 2

=	Robert Earll			Gabie 1	lemple		
9	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address	(Street and Number or Rui	ral Route Number, City	or Town, State, Zij	o Code)
	Margaret A. Earll	(Spouse)	1611 High	land Drive, S	Silver Spri	.ng, MD 2	20910
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Plac	e of Disposition (Nar etery, crematory, or of Metropoli Cremator	ther place) June Lan y 201	e 8, 10 A1		Town, State
	21. Signative of Juneral Service License	MQ0689		d Address of Facility De Deer Park Di			MD 20877
	23a. Part 11 Enjer the cisease, or complice shock bettern failure. List only one dimmediate Cause (Final disease or condition resulting in death)	ations that caused the death. Ecause on each line.  Anemia of Characteristics and the control of	ronic Ill		or respiratory arrest,		Approximate Interval Between Onset and Death
5	Sequentially list conditions, 5	Chronic Rena	l Failure				
2	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a consequen					
alcal E	resulting in death) Last	Due to (or as a consequen	ce of):				
ysiciall/line	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal di 4  Pregnant at time of dea 9  Unknown	eath 3 DEctopic			23d. Date of de Month	livery Day Year
n Dy L	Part II. Other significant conditions control Hypertensive Hear		ng in the underlying	cause given in Part I.			o the cause of death?
nalaidillo	Gastrointestinal Atrial Fibrillati				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
2	25. Was case referred to medical			26. Place of Death (Chec	ck only one)		
2	1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF	NOutpatient 3 🗆 D	OA Other: 4 🗆 Nursing H	lome 5X Residence	6 Other (Spec	cify)
IIIICale:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident □ Investigation	28a. Date of injury (Month, Day, Year) 28	Bb. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
5	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
Nealcal	(Check 2 Medical Examine)	ian: To the best of my knowled r: On the basis of examination a Practioner: To the best of my kr	nd/or investigation, in	my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner stated.
	29b. Signatura and jule of certifier			. License number		Date signed (Mont	

D25344

3905 National Drive, Burtonsville, MD 20866

06/07/2010

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Jay
31. Date filed (Month, Day, Year)
WIN 0 9 2010

Robert Jay Ginsberg, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Olo D:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 419 North Carolina Avenue Pasadena 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Months Hours 08/07/1924 Director 059-16-3854 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 419 North Carolina Ave. 21122 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. W Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced White WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mortgage Loan Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ellen O'Rielly Valentine Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin M. Flynn/Son 13304 Yorktown Dr., Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem: 06/08/2010 4 Donation 5 Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwv., Bowie, MD 20715 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each kile. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year the 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖼 o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy death? perform Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 36 ဂ္ 4 ☐ Nursing Home 5 Mesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 9522 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Day</sup> 2010 Jose Desiderio Fiestas 3:30 A 05 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Village Montgomery Montgomery Village Health Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 88 Months Dec. 21 Hours Peru 216-53-8086 1921 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Honey Brook Circle 20878 Peru 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. Yes 2 No Completed by 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Peruvian White If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Textiles Salesman 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Santos Fiestas Maria Querevalu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Lopez (Daughter) 17 Honey Brook Circle Gaithersburg, MD 20878 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place June 2010 permit. Page Department ( Important: If any injury or once. All Souls Cem. Germantown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home with 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke disease or condition resulting in death) Due to (or as a consequence of): Dementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown

Physician/ Medical Examiner

should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho.

if. Page 1 and 2 shours and Meath and Mr.

If item 27 is marked other than "natur or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tranthe detached ģ sate has been signed page 2 should be del this certificate within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral

æ 2

Certificate:

Medical

or Attending Physician: The law requires that the death certificate be executed

the Hospital

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
	_

24a. Was an autopsy perform Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

examiner?			26. Place of Death (Check only one)								
1 Yes 2	No.	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3 ☐	DOA Other:	4 🛚 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)					
P.7. Manner of Death  1	5 Pending Investigation		28b. Time of injury	28c. Injury at work? 1  Yes	_	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b			tory, office		28f. Location (Street and Number or Rural Route Number,					

4 Homicide determined building, etc. (Specify) 29a. Certifier

Gertifying Nurse Exactioners To the best of my

Example 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. businedge, death becamed at the time, date and plane, and due to the nause(s) and manner as stated

City or Town, State)

29b. Signature and titl f certifier e an Orress of person who completed cause of death (Item 23a) (Type, Print)
Anushiravan Dadgar M.D. 10110 Molecular Dr. Suite 206 Rockville, MD 20850 30. Name an

29d. Date signed (Month, Day, Year) June 7, 2010

State Registrar 31. Date filed (Month, Day, Year) JUN 08 2010 32. Registrar's Signature

29c. License number

H 51280

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2010 Physician/ June **FELDER** Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly Prince Georges Hospital 8. Date of Birth (Month, Day, Year) 1 1942 Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 X F Director 67 577-58-9650 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the state. 10c. City, Town or Location 10a, State 10b. County Director 1X Yes 2 ☐ No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20019 4800 East Capitol St NE #317 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Deli Clerk Giant Foods 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Shuler John B. Felder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Upper Marlboro, MD. 20772 Richard Felder - Son 7807 Locris Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6-12-2010 Washington National Suitlnad, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Marshall's Funeral HOme of Maryland
4308 Suitlnad Rd. Suitland, MD. 20746 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 X No n signed by the a Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 🕅 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: A Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: Type best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ne and address of pers n 23a) (Type Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. 6904 6/30/10 dk

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Talbott. Glen Friedly June 3 2010 3:20 ам Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death
Mardela Springs **Examiner** 4c. County of Death W1COM1CO 10500 Riverton Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours West Virginia 218-26-5944 0672771930 79 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Mardela Springs 1 ☐ Yes 2 X No Maryland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral with 1 21837 USA 10500 Riverton Road 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Midowed 4 Divorced Completed white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) diesel mechanic Alban Lift Truck Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ೭ Glenna Irene Eurlywine Talbott Birch Friedly 19a. Informant's Name/Relationship (Type, Print)
Sharon Anderson/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 10500 Riverton Rd., Mardela Springs, MD 21837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Riverton Cemetery 6/8 2010 Mardela Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) sonhagea Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown the s been signed by the should be detached Hospital or Attending Physician; The law requires that the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 X N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 🖪 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After properties of the function of the fun 1 ☐ Yes 2 ☐ No. Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F complet only one 29b. Signatui 29c. License number 29d. Date signed (Month, Day, Year) 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) HLOY egistrar's Signati State JU# 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 📗 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ John C. Gibson 2010 1:48 A June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly Prince George's County Hospital 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year) Jan. 5, 1922 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours Months Director 88 175-18-7388 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2025 Woodshade Ct. 20721 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Ves 2 No \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Widowed 4 X Divorced Year or Dates. 44-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Hubert Gibson Evelyn Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2025 Woodshade Ct., Bowie, MD 20721 John C. Gibson, Jr. Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/04/2010 Baltimore, Maryland 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Empherema Immediate Cause (Final Physician disease or condition Medical resulting in death) HEART Failure Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury SEWEN Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier micenne And eller, und D0059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andella, um mucemi 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

JUN 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#19B per FH State of Mary State 6/8/2010 AACO HEALIH DEPT CMH Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death gent's Name (First, Middle, Last) 3. Time of Death Physician/ MAY 345 20010 Medical Town, or Location of Death 4c. County of Peath Name (if not institution, give street and number) **Examiner** trovasi If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days Hours 06/10/1949 Pennsylvania Months 1 XM 2 □ F 179-40-0058 Director 60 Usual Residence of Decedent 3a or 28a-f show be notified at 10d, Inside City Limits 10h. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 XNo Crofton Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral er than "natural", or items 23a the Medical Examiner must b USA 1722 Peartree Lane 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) U.S. Government permit. Page 1 and 2 should be filed within 75 Det artment of Health and Mental Hygiene. Important. If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Treasury Department Systems Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Kieszek Zigmund Geida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Peral Poute Number, City or Town, State, Zip Code) 1722 Peartree Lane, Bowie, MD 21114 Lynn E. Geida/Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 06/05/2010 4 Donation 5 Other (Specify) Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or deach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner 105 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Records, has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? page 2 autopsy performed Yes 2 1 🗌 Yes 2 🗎 No certificate 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) director Be 2 1 No Yes ပ 1 🔲 Inpatient 2 🕽 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this ( funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier The design of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The design of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The design of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2010 June 4:54 PMGEORGE STEVENSON GROOM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset 26906 Fairmount Road Westover | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 25, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 68 Yrs. Months 1 X M 2 □ F 215-40-0201 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show iral", or items 23a or 28a-f shov Examiner is ust be notified at 1 □Yes 2 X No **Funeral Director** Westover Maryland Somerset the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 26906 Fairmount Road 21871 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Merhal Hygiene.
Int: If item 27 is marked other than "natural", or liter any or other traumatic event, the modical Extraction any or other traumatic event, the modical Extraction 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify. Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Machine Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Dawson Thomas Groom Elizabeth Stevenson Stoakes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fairmount Road - Westover, MD 21871 Brenda Lee Groom (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify)
Signal Fune at errite License
Mary Boarn Brads Crematory of Delmarva June 4, 2010 | Delmar, Delaware 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** N disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the detached f 9 I Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u></u> 2 🗌 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an autopsy certificate 1 ☐ Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only

State Registrar

HI

29b. Signature and title of certifier

the

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29c. License number

Cristile us

29d. Date signed (Month, Day, Year)

June 3, 2010

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day June 2010 Year 8 4:20 A M David Goldstein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Home Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 15, 1923 1 X M 2 □ F Months Days Hours Min. Pennsylvania 86 Director 197–16–5879 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 🗌 Yes 2 🖳 No Maryland Montgomery Potomac 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Examiner must be Funeral items 23a 9028 Marseille Drive 20854 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 'natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1942–45 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 lin and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the <u> Metallurgical</u> Engineer Research & Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martin Goldstein Anna Moldovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Potomac, Maryland 20854 Estelle Z. Goldstein/wife 9028 Marseille Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 6/9/2010 | Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig 1 fure of Funeral Service Sing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M Line M00957 MDthomas 23a. Parkt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 the attending phed for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No Unknown 9 Hinknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Records, Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 1 ☐ Yes 2 ☐ No Yes 2 XN Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital 1 Yes 2 🕅 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. Accident Investigation Director: A 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, hin 24 hours a the Funeral D Hospital Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D0062435 June 8, 2010 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Sayed Eisayyad

Rockville, Maryland 20850

10110 Molecular Drive

istrar's Signature

1 - For State Registrar

Director

Funeral

Be Completed by

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For State Registrar		State of Ma	-			f Health a of Death	and Me	, ,	ene	n i o	70000	
	e (First, Middle, Las	t)						2. Date of Death	2.00	UIU	3. Time of Death	
Rene		Gonza	102					Month 6	Day	Pear 2010	515 PM	
	If not institution, give	street and number)				n, or Location o			4c. Count	. County of Death		
	el Pre R					ver Sp						
5. Social Security N 578-13-	-2045 1		(In yrs, last birth	//	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day, 1) 4 / 1 3 / 1	952	9. Birthpl	ace (State or Foreign try) alvador	
Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town of	or Loca	tion					1	0d. Inside City Limits	
MD	Montgo	mery			Spri						1 Yes 2 No	
10e. Street <i>a</i> nd Nu 3814 Be	el Pre R	oad #2			10f. Zip Code	o 906		100		What Coun	try?	
11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. Wa	as Decedent o	of Hispanic Ond Juban, Mexican	gin? (Spec	cify Yes or No-		ce - America		
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3 Widowed	4 Divorced	Year or Dates:				Sallva	adora	an	Speci	<sup>Ŋ:</sup> Whi	te	
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Elementary/Seco	ndary (0-12)	College (1-4or 5-	1 1 _	_		t Cook			Res	taura	ant	
17. Father's Name Jose Ma	(First, Middle, Last) aria Fue	ntes						(First, Middle, Ma Gonzal		me)		
	ame/Relationship (7)							Route Number, 0			Code) g,Md20906	
20a. Method of Dis	·		20b. Place of D	Disposit	ion (Name of					- City or To		
	☐Cremation 3 ☐I		Gate Gate	of of	torý or other p Heave	en 6	/04/			•	ring,Md.	
	uneral Service Licens	_/_/		P#1	Namaanda 11 Col	PreRIMA umbia	LDI Blv	FUNERA d.Silv	L SEF er Sp	RVICE	,P.A. ,Md20910	
23a. Part1. Enter t	the wease, or comp	olications that caused one cause on each line	the death. Do no								Approximate	
Immediate Cause	(Final		<del>;</del> .								Interval Between Onset and Death	
disease or condition resulting in death)		a. Due to (or as a	consequence of	):	- 1							
Cognopticity list or	aditions	h										
Sequentially list co if any, leading to in cause. Enter Under Causes, Disease of	nmediate erlying	Due to (or as a	consequence of	):								
that initiated events resulting in death)	6	C										
resulting in death)	Last	Due to (or as a	consequence of	):								
		d										
IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 1 9 Unknown	months?	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	Fetal death		ctopic pregna Other <i>(specify)</i>					ate of delive	ory Day Year	
Part II. Other signi	ficant conditions co	ontributing to death bu	not resulting in t	he und	erlying cause	given in Part I.		23e. Did toba	cco use cor	ntribute to th	e cause of death?	
Diabe	tes		-					1 ☐ Yes			ably 4 □Unknown	
Duso	hagia							24a. Was an		. Were auto	psy findings available	
Coast	hs = 1	3I bleed	ina		<del></del>			autopsy performe	ed?	prior to cor death?	npletion of cause of	
25. Was çase refe	1112	- 01000	1413			26. Place	of Death	1 Yes 2! (Check only one)		1 □ Yes	2 □ No	
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatier	t 2 ☐ ER/Outp	atient	3□ DOA	Other:	rsing Hon			ther (Snecifi	<i>(</i> )	
27. Manner of Dear	th	28a. Date of Injur	/ 28b. Tir			njury at Vork?		8d. Describe how			'/	
1 Natural 2 Accident	5 ☐ Pending investigation		, sar/ inj	ur y		vork? □ Yes 2 □ I	No					
3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Could not be determined 8 ☐ Could not be determined 8 ☐ Could not be determined 9 ☐ Coul												

Examiner Physician/Medical Certification: To Be Completed by

Gastritis c	6I bleeding		performed? death? 1  Yes 2 No 1 Yes 2 No				
25. Was case referred to medical examiner?	3	26. Place of Death	(Check only one)				
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient	me 5 Residence 6 □Other (Specify)					
27. Manner of Death  1 Natural 2 Accident  5 Pending investigation		28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)	28f. Location (Street and Number or Rural Route Num City or Town, State)					
29a, Certifier 1 Certifying Pr	urse Practitioner	occurred at the time, date and place	and due to the cause(s) and manner as stated.				
The second secon	.,	reserved at the time, date and place,	and due to the cause(s) and mainten as stated.				

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Silver Spring, Md

29c. License number 2098788 CRMP

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

May Blanker CRM 11860 Tech R

(Month, Day, Year) 31. Date filed 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Month, Day, Year)

June 4, 1921 1 M 2 A F Days Months Hours Ok Lahoma Yrs Director 444-16-7785 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10h County 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4714 Colonel Darnell Place 20772 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Shockley James Redmond Prewitt Jimmie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie K. Hope/daughter 4714 Colonel Darnell Place Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/9/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Going Home Cremation Service P.O. box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 earth Homas 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 WNo Month Year Day Pregnant at time of death 9 Unknown Part II ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ ARDIOMYOPATHY Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been siç r, page 2 should b Completed ATRIAL FIBRILLATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 Yes 2 No Hospital or Attending Physician; of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) MWDR/ 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation within 24 hours after deatl

To the Funeral Director;
completed filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Sign 29d. Date signed (Month, Day, Year) 06 Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

State Registrar

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 06/05/2010 ar **Physician** 1:45 pM Elizabeth Dolores Hanson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Dunkirk 10604 Taney Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/01/1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min 1 □ M 2 🙀 F 197-16-5756 PA 86 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experiment must be notified at 1 ☐ Yes 2 X No Dunkirk Director Calvert 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 20754 10604 Taney Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth P. Rigby Vincent P. Monaghan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 10604 Taney Court, Dunkirk, MD 20754 Dawn Ackermann/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If i
any injury or 06/14/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Sign tre Funeral Serv Lisa M. Mounts 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. been signed by the should be detached 9 HInknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b performed2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After thi funeral 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after uc...

To the Funeral Director: After a contract of the funeral by the funeral part of the funeral part 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

JRW

State Registrar

(Check only one)

Kaymon

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

324

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 4, Cecilia Pingel 2010 Hargis 6:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 465-67-6269 55 Brazil Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland | Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8225 Canning Terrace 20720 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1♥Yes 2□No Specify: Brazilian If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Self-Employed Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Maria DaPenha Carvalho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viorel Tatu, Husband 62-27 Boelsen Crescent, Rego Park, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 6/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, 4400 Powder Mill Rd., Beltsville, MD 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Immediate Cause (Final 9nset and Death years Physician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): I-transit that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician a page 2 should be detached for use as the bunal-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 10 June 5, 2010 D54378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd. W., Ste. 400, Wheaton, MD 20902 Dr. Cheryl A. Aylesworth, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JUN 09

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registr <i>ä</i> r	State of Ma	aryland / Depa Cea		of Health of Death	and M	lental Hy	giene Reg. No.	2010	9533	
			Hegistrar  1. Decedent's Name (First, Middle, Last)							2. Date of Death		3. Time of Death	
	Physicia		Eva Evelyn Carpel Hoffman							05 <sup>Day</sup>	20 To	12:15 PM	
	Medi Examir		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or Location of Death			June 05 2010 12:15			
100	/		Carriage Hill Nursing Home				Bethesda			Mo	ntgomer	у	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth 9. I			place (State or Foreign	
	Director		<u> 137-18-2704   </u>	□M2 <b>X</b> IF	88 Yrs.	MONTHS	Days Hours	IVIIII.	05/16/	1922	New New	Jersey	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	nation						10d. Inside City Limits		
(K					Bethes							1 🕅 Yes 2 □ No	
X			MD Montg		10f. Zip Code			10- Citi-	en of What Cou				
,		<u>a</u>	5215 West Cedar		Ton Lip o			ed Stat					
		Ę.	11. Marital Status	ver in U.S. 13.1	13. Was Decedent of Hispanic Origin? (Spec			cify Yes or No-	14	I Race - Americ	American Indian,		
920		ed by F	1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 I If Yes, Give Year or Dates.	No.	If Yes, specify	Cuban, Mexica No Specify	n, Puerto F	Rican, etc.)		Black, White, pecify: White	etc.	
9		lete	15. Decedent's E		Decedent's Usual Occupation				16b. Kind	d of Business In	dustry		
21	in 72 e. nan "	Ĕ	(Specify only highest gr Elementary/Seconday (0-12)	+) (Give life. D	e kind of work done during most of working DO NOT use retired)								
7	with gien her th	ပြွ		4		nemaker	:			Ow	m Home		
pu	age 1 and 2 should be filed ent of Health and Mental Hy nt. If item 27 is marked oth y or other traumatic even'	o Be	17. Father's Name (First, Middle, Last)						(First, Middle,		rname)		
yla		₽	Samuel Sagotsky		. ,		Sop	hie (	Gluckma	n			
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship (1 Beth Carpel / d	,, ,			Street and Numb		Route Numbe ne Sp	r, City or To	own, State, Zip ( Creek,	NV 89815	
			20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispo	natory or othe	er place)		ate / 2010		ation - City or To	own, State	
湟	ortan injur		21. Signature of Funcial Service Licen		Congregat	. <b>10n Ce</b> 2. Name and A	metery! Address o <b>Traci</b>	tzansl	cv-Gold			1 Chapel In	
99	Depar Depar Impor any ir		1	M0116			ckville						
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do not ente							Approximate	
	Pnysician/		shock, or heart failure. List only of Immediate Cause (Final	oric t	s type					Interval Between Onset and Death			
	Medical		disease or condition resulting in death)	er s cype									
	Examiner												
		ner	Sequentially list conditions, if any, leading to immediate	consequence of):									
	uted Id ansit	am	Cause (Disease or iinjury that initiated events	C									
	exec an ar rial-tr	l <u>ũ</u>	resulting in death) Last	Due to (or as a	consequence of):								
09	ate be executed oblysician and the burial-transit	dical Examiner		l d									
6876	tifical ng ph		IF FEMALE:										
9 ×	h cer tendi r use	Physician/Me	23b. Was decedent pregnant	1 Live Birth 2	3c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy					23	d. Date of deliv	*	
Вох	deat he at ed fo	sici	in the past 12 gronths? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown						Month	Day Year	
P.O.	it the by the	Phy	9 Unknown  9 Unknown  9 Unknown  9 Unknown  9 Unknown										
S, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Panhypopituitarism							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 X☐ No 3 ☐ Probably 4 ☐ Unknown			
oro	v req	Set	Dysphagia							24a. Was an 24b. Were autopsy findings available			
ĕc	he lay te has age 2	mo		autopsy prior to completion of cause of death?  Yes 2 \( \bar{\Delta} \) No: 1 \( \bar{\Delta} \) Yes 2 \( \bar{\Delta} \) No									
F	ifficat	Be C									2 L NO		
Ζį	ysicit s cer direct	To B	examiner?								d		
Division of Vital Records,	g Ph er thi		27. Manner of Death	28a. Date of injur	y 28b. Time of	. Injury at work?			cribe how injury occurred		/		
n	nding ath. :: Afte e fun	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year) injury	М	work? 1 \( \sum \) Yes 2 \( \sum \)	No					
<u>S</u>	Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm, str			2		(Street and Number or Rural Route Nu		Route Number,	
Ş.	s after			building, etc. (Specify)					City or Town, State)				
_	Hospit 24 hour Funers	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								use(s) and manner stated		
	o the vithin o the omple	Σ	only one) 3										
	D35579 296, Date signed 1 296, D									7/2010	)10		
De Just av													
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Susan J. Miller, M.D. 8218 Wisconsin Ave. #305 Bethesda, MD 20814										
	Sta	e.	31. Date filed (Month, Day, Year)				- "303	Det					
	Registr		31. Date filed (Month, Day, Year) JUN 0 9 201	annua	Di Anna	Kind							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June VERNON **EUGENE** HAM 2010 10:10 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death E. Boniwood Turn Prince Georges Clinton Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 27, 1932 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Director 246-40-4980 78 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 K No MD Prince Goerges Clinton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5928 E. Boniwood Turn 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛂 No Black, White, etc. 1 Never Married 2 Married ☐ Yes Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Black Year or Dates marked other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Truck Driver Dept. of Public Works Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hortense Holman Johnny Ham and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Boniwood Turn Virginia Ham - Wife 5928 Clinton, MD. 20735 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cem | 6-11-2010 Suitland, MD. 21. Signature of Puneral Service Licensee Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ congestive Heart Fair disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Advanced Demention Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Stroke Hospital or Attending Physician: The law requires that the death certificate be executed and l physician ar s the burial-tı resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mannar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? ☐ Accident ☐ Suicide 2 🗌 No Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3[ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 12010 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

JUN 0 9 2010

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Maryland / Department of Health State Registra-Amend#1.PerPhys.PGC6-17-10cr Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROMONA F. HIGHTOWER 6/6/2010 Day RAMONA F. HIGHTOWER 9:25 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SILVER MONTGOMERY COUNTY HOLY CROSS HOSPITAL SPRING Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Min. 10/1/1928 Hours Director 81 492-26-8285 TULSA, OK Usual Residence of Decedent 28a-f shov 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 💂 Yes 2 🗌 No MD MONTGOMERY SILVER SPRING 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 COLESBERG STREET 20905 UNTIED STATES Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ Black, White, etc. 1 Never Married 2 3 Married ☐ Yes 2 🔭 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give BLACK 3 🗌 Widowed 4 🔲 Divorced Completed Specify: Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12years EXECUTIVE SECRETARY year GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BURL HENRY SALLIE MAE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIVIAN A. POLLARD/ daughter 2008 FOX MEADOW WAY BOWIE, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 🗗 Cremation 3 ☐ Rev cemetery, crematory or other place) loval from Sta 4 Donation 5 Other (Specify TVERDALE PARK 6/9/2010 RIVERDALE, MARYLAND Signature of Funeral Service 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME 3005 12th ST. NE WASHINGTON, DC 20017 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ ADENOCARCINOMA, UNKNOWN PRIMARY disease or condition nonths Medical resulting in death) Due to (or as a consequence of): Examiner SEIZURE DISORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events weeks Examiner Due to for as a consequence of MALIGNANT PLEURAE EFFUSIONS weeks physician ar s the burial-tr Due to (or as a consequence of): resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? TYPE 2 DIABETES MELLITUS, HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? MENINGIOMAS IN BRAIN 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Supunich RSM MD 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA SUPANICH 1500 FOREST GLEN RD. SILVER SPRING, MD 20910 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:20 P M Helen Justine Hill 2010 Medical June 2 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2**X** F Feb. 28 Country) Maryland Hours Year 1926 84 Director 577-30-9336 Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director P.G. 1 X Yes 2 No MD Hyattsville 10e, Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any niury or other traumatic event, the Medical Examiner must be a Funeral 7900 Kreeger Drive 20783 U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 XNo 3altimore, Maryland 21215-0036 African-American If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Chef Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry P. Swann Helen Marie Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell Swann-Son 7900 Kreeger Dr., Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State George Wash Mem. Pk 6-11-10 Hyattsville, MD 4 Donation 5 Other (Specify) 21. Signature Juneral Service Licens 22. Name and Address of FacilityBonnette & Assoc. Funeral Home 2504 28th St., N.E., WDC 20018 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify iours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? X Natural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical

within 2 To the 6

State Registrar

29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cartilying Nurse Practioner: To the best of my knowledge

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

465.

29d. Date signed (Month, Day, Year) JUME 3 2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2010 Physician/ 3 11:30AM June Holden Callena Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hyattsville 1836 Metzerott Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 25, 1937 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🗌 M 2 🕱 F Country) NC **Director** 579-50-4653 Dec. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No Hyattsville PG MD 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral 20783 United States 1836 Metzerott Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or ģ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Private or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Tillery Beatrice Jones James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other tra Grove Lang 0678 Dugue/daughter Tracy 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/12/10 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park Landover, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Suitland, Md. 20746 Silver Hill Rd., art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
16 Months mmediate Cause (Final Physician/ Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attending should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown or Attending Physician: The law requires that the death eafter death. Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Fes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 performed' 1 Yes 2 No 1 Yes 2 L within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 4 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier Certifying Physigian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signatur D00754 completed cause of death (Item 23a) (Type, Print)

CL 5 State

DHMH 17 Rev 7/2009

Registrar

JUN 0 9 2010

CIBINGEY

Greenway Center Dr., Greenbelt, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Huddleston June 6 0438 Jonas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Saint Mary's Saint Mary's Hospital Leonardtown 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Min Hours Director Yrs. 80 245-40-5706 1 9 310 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Charlotte Hall Saint Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DC Government Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Huddleston Jonas Lizzie McBrayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 Fletcher Avenue Vernana Huddleston/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 6/11<sup>Date</sup> 0 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cheltenham, Md. Md Veterans Cemetery Signatu of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Hill Rd. Suitland. Md.20746 Silver 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final Onset and Death Physician/ ata disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Unonary attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Box 687 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 Yes 2 L 9 Unknown Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performe Yes 2 [ this certificate 1 Tes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ၉ 1 🗆 Inpatient 2 🗡 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral L Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completed t Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practiciner: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as all about. (Check

Registrar

29b. Signature and title of certifier

JUN 0 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

25500

29c. License number

Coint Lookaut RD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			= For Amend Items State Registrar	28tate of	/arvien	g <b>oo</b> pgo Cer	tificate	2010 of D	eath	and M	lental Hy	giene Reg. No		19539
	Dhysisis		1. Decedent's Name (First, Middle, Las	st)							2. Date of De		y Year	3. Time of Death
	Physicia Medic							Howes Jur					10 Year	12:04 a <sup>M</sup>
	Examiner  4a. Facility Name (if not institution, give street and number)								Location o	of Death			County of Death	
			Suburban Hos  5. Social Security Number 6. S		0 1-	and to both adapt A	Beth If Under		If Under	OA Uro	0 = 1 (5)		lontgome	<del></del>
	Funeral Director			ex □M2XxF	.ge (In yrs. la 52	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 10/15/	tn 17, Year) 1057	9. Birti	nplace (State or Foreign ntry)
			Usual Residence of Decedent		32						10/15/	1337	Wasi	Tington, DC
Co	/land f sho	tor	10a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside City Limits
10	Man 28a- otifie	irec	Maryland Montgom	ery	G	ermant	_							1 🛣 Yes 2 □ No
V	th the	al D	10e. Street and Number				10f. Zip					10g. Cit	izen of What Cou	intry?
(	ath wi	Funeral Director	11418 Locustdale	Terrace 12. Was Decedent	From in 11 C	10.1	208			i-0 (0	-i4 . \/ N  -	USA		
(0	or ite	by Ft	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☑ Married</li></ul>	Armed Forces	?	i.   13. v	Yes, speci	fy Cubar	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)		<ol> <li>Race - Ameri</li> <li>Black, White</li> </ol>	
030	rsafte ral", Exar	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	40	1	☐ Yes 2	№ No	Specify:				Specify: Wh	ite
5-0	2 hou "natu	Completed	15. Decedent's E (Specify only highest gr		1.	16a. Deced	lent's Usua	Occupa	tion	of worki	na .	16b. Ki	ind of Business I	ndustry
77 5	hin 73	mo	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO	O NOT use		anny most	. Or WORK	ng .	ľ _		
12	Hygie	Bec	12 17. Father's Name (First, Middle, Last)			Secre	etary		40 14-11-		/Fire 4   4   4   4   4			vernment
and	be file ental ? ked o ic eve	2	Bernard Levin						Ruth		(First, Middle,	Maiden S	Surname)	
ary	nd Mi		19a. Informant's Name/Relationship (T	vpe, Print)		19b. Mailin	a Address	(Street a				er. Citv or	Town, State, Zip	Code)
$\mathbf{Z}_{\mathcal{R}}$	d 2 sl alth a n 27 is ertra		Roy Howes, husbar	nd			_						town, MD	
Sre	of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑	lm u o	20b. P	lace of Dispos			, !	[	Date	20c. Lc	ocation - City or T	own, State
) E	Page ment tant: I ury o		4 Donation 5 Other (Special		Kir					6/03	/2010	Fal:	ls Churc	h, Virginia
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		01255								HAPELS,	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that cause ne cause on each li	ed the death									Approximate
1	nysician/		Immediate Cause (Final disease or condition	Traumat		ain In	iurv				,	1	<b> </b>	Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):		_			1		CM	)
		e.	Sequentially list conditions, if any, leading to introdicts	b. Gunshot	Woun	d to t	he He	ad			A	ea T	7 1	
47	nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Suicide		erale oi):		1 1	\	$\sim$	1)4	4		0
9000 T	n and al-trai	Exa	that initiated events resulting in death) Last	Due to (or as		ence of):		$\overline{}$	700	, ,	1	(0	7 /	<u> </u>
8	certificate be exected and nding physician and use as the burial-transit	dical		d										
2	tificat ng ph as th	Med	IF FEMALE:						d				,	
× 0	tendir tendir	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live Birth			Ectopic p	regnancy	,			- 1	23d. Date of deli	
	e deat the at ned fo	Physician/Me	1 Yes 2 X No	4 ☐ Pregnant 9 ☐ Unknowr		eath 5	Other (spe	ecify)					Month	Day Year
0. 0.	at the	h H	Part II. Other significant conditions o	ontributing to death	but not resi	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco u	se contribute to	the cause of death?
S, F	r requires that the death certificar been signed by the attending pt should be detached for use as the	d by									1 🗆	Yes 2	□ No 3 □ Pro	obably 4 🔀 Unknown
of Vital Record	w requ	Completed									24a. Was			opsy findings available
WEN D	Physician: The law this certificate has al director, page 2 !	E O										psy ormed? 2 🔯 No	death?	ompletion of cause of
<u>a</u>	ian: 1	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Deat	th (Check		Z <b>ZS</b> 140	7 1 163	2 🗆 110
≥ ₹	hysic his ce	2	1X Yes 2 □ No			ER/Outpatien	t 3 🗆 DO	A Other	r: 4 □ Nu	ırsing Ho	me 5 🗆 Resi	dence 6	Other (Special	(y)
- 0	ing P	ate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of in (Month, D		28b. Time of injury	28	c. Injury work?	,		28d. Describe	how injury	- /	ject shot
Si Si	Attendi death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 X Suicide 6 Could not b			2015			res 2 🗷		2000	[פנ		self
WES Division	spital or Attending Phours after death. eral Director: After th	Se	4 Homicide determined	building, e	tc. (Specify)	Howard And Silver	-	onice			City or Tou Terrac	street and vn, State) <b>e - Ge</b>	11418 I rmantown	ocustdale
HOWES Division	Fun Fun	edical	29a. Certifier 1 XCertifying Physic (Check 2 Medical Example)	mer: On the basis of	examination	edge, death o and/or invest	ccured at t	y opinior	n, death oc	olace, and	d due to the ca	ause(s) an	d manner as stat	ed. ause(s) and manner stated.
	To the To the To the Comple	Σ	only one) 3 Certifying Nuy 29b. Signature and title of certifice	Practioner: To th	e best of my	knowledge, d		ed at the License		and plac	e, and due to th		and manner as s e signed (Month,	
•	12		•	Qu.	ψ		_	4	2-13	1		7	une/	st, 2010
			30. Name and address of person who	WEZY	ER	SAND	rint)	<b>\</b> 11	11119	Roc	kville	Pk,	Rockvi1	1e, MD <sup>2</sup>
	State Registra	٠	JUN 0 9 2010	32. Regist	trar's Signat	park					<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19540 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7 June 10:30 P M Wyotta Miller Holden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 11708 Eden Road 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days July 1, Year) 917 1 □ M 2 🔀 F 92 Wisconsin 357-09-0863 **Director** Usual Residence of Decedent mit, Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 🕅 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 11708 Eden Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant State Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jarvis Miller Clara George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11708 Eden Road, Silver Spring, MD 20904 Stanley E. Holden, Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Lincoln Cemetery | 6/11/2010 Ft. Brentwood, Maryland 4 Donation 5 Other (Specify) <sup>22 Name and Address of Facility</sup> Tonald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD 20705 21. Signature of Funeral Service Licenses ned 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelofibrosis Physician/ Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has boon account. Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached f 1 ☐ Yes 2 Ł 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 5 Residence 6 Other (Specify) ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D54378 June 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Cheryl A. Aylesworth, 2730 University Blvd. W., Ste. 400, Wheaton, MD 20902

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

92 Boois

			For State Registrar	State of Maryland	-	artment of H			iene () (	19541
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	- II				2. Date of Death  Month June	Day Year	3. Time of Death
	Medic	cal								
	Examir	ier	SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY							
	Funeral Director		164-28-7262	7. Age (In yrs. last)	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan• 20	Year) 9. B	irthplace (State or Foreign country) MD
	ind show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation	<u> </u>			10d. Inside City Limits
	Maryla 18a-f tiffied	rect	PA York		New	Freedom	ı			1 ☒ Yes 2 ☐ No
	a or 2 be no	Funeral Director	10e. Street and Number	<u> </u>		10f, Zip Code		1	0g. Citizen of What (	Country?
	th witi ms 23 must	iner	244F N. Second		1.0.		349		U.S.A.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4X Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🛛 No		ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
2-0	2 hour	plet	15. Decedent's Educ (Specify only highest grade		6a. Deced	lent's Usual Occupa	ation Juring most of work	ina	16b. Kind of Busines	s Industry
121	thin 7	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife. D	ONOT use retired) nine Ope	_	, I	Manufac	turing
	led wi Hygie other ent, tl	Be (	17. Father's Name (First, Middle, Last)			1	18. Mother's Nam	e (First, Middle, M		
<u>la</u> n	d be fil dental irked tic ev	잍	Walter T. Fran	k				F. Bel.		
Maryland	should be filed vand Mental Hyg rand Mental Hyg rs marked othe raumatic event,		19a. Informant's Name/Relationship (Type	· · · · · · · · · · · · · · · · · · ·		-			City or Town, State, 2	
	and 2 lealth em 27 ther tr		Barbara A. Rosie 20a. Method of Disposition							
Baltimore,	age 1: ant of I it: If its y or of		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Mf <sup>e</sup> T	Ters	sition (Name of natory or other place Unite	a Jun	e 21,	20c. Location - City of Millers	MD
altir	mit. P. sartme sortan / injur.		21. Signature of Funeral Service Licensee		hodi 22	st Cem.  Name and Addres	ss of Facility, T	Harter		tuary Inc.
Ä	Depar Impo	V. V	Med W. M	Kurane		24 N. Se	econd St	. New	Freedom	, PA 17349
	nysician/	K 19	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Decause on each line.  Acute Respli  Due to (or as a consequence)		685		or respiratory arres	st,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	-						6 days
		Je.	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	ALVEOLAR Due to (ur as a consequence	<b>. 17</b>	21701QCH	1446			O days
	nath certificate be executed attending physician and for use as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	MYO CARDI Due to (or as a consequence	AL ce of):		6 days			
09/	physic the b	edic	d.							
. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed the Ab hours after death. The Ab hours after death. The Abril State death the State of the Abril State of the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1  Live Birth 2  Fetal de 4  Pregnant at time of deal 9  Unknown	eath 3	Ectopic pregnanc Other (specify)	у		23d. Date of o	delivery Day Year
P.0	that the ned by detact		Part II. Other significant conditions cont	ributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	v requires that is been signed k	Completed by	DIABETES, HYPS	PRTENSION,	COK	LONARY.	ARTERY	1 1 Ye	es 2 🗆 No 3 🗆	Probably 4 🗆 Unknown
Records,	law rec has be je 2 sho	nple	DISEASE HYPER					24a. Was ar autops	y prior to	autopsy findings available o completion of cause of
Re	sician: The Is certificate h rector, page		PARKINSONISM	, CHRONIC K	IDENE	y DISE	ase,	perform 1 Tes 2		es 2 No
ital	sician: The certificate rector, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	spital:		Low	ace of Death (Checker:	The same of the sa		
of Vital	g Phys er this eral di	e: 70	27. Manner of Death	1 ☑ Inpatient 2 ☐ ER 28a. Date of injury 28	b. Time of	28c. Injury	4 □ Nursing Ho / at	ome 5 LReside 28d. Describe ho	nce 6 Other (Spewinjury occurred	ecify)
on	ending Path. Pr: After he funer	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 □	? Yes 2□No			
Division	ital or Attendi irs after death al Director: A led in by the fu	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examine	an: To the best of my knowledger: On the basis of examination an Practioner: To the best of my kn	d/or inves	tigation, in my opinio death occurred at the	on, death occurred at e time, date and place	t the time, date and ce, and due to the	d place, and due to the cause(s) and manner	e cause(s) and manner stated as stated.
	<b>7</b> . № 6		The lend in	Tongl MD.		29c. License	number - 000	i	9d. Date signed (Mor <b>ブ</b> むいと , 16	
			30. Name and address of person who con	pleted cause of death (Item 23			TAL OF			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	. 0	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month 6 Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BR Un 8. Date of Birth (Month, Day, 8/12/ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min. 1 № M 2 🗆 F Months Days Hours 214-34-8937 79 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State death with the Maryland **Funeral Director** MD Worcester Berlin 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21811 9715 Healthway Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 1 Yes : Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Paint Store Operator Owner Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic access 17. Father's Name (First, Middle, Last) Emma Katherine Wooten Charles Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Berlin, ND 21811 10042 Friendship Rd., Janet J. Lathbury daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Park 16/10/2010 Berlin, MD Mem. 22. Name and Address of Facility Burbage Funeral Home St., Berlin, MD 21811 108 William 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final no Vasc Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 1 Yes 2 No **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending Natural 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3.1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) DN 6+1 31. Date filed (Month, Day, Year State Registrar

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JOHNSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DAVID JOHNSON SR. 11=16 AM June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 QM 2 DF Days Hours Min Months JAN 1937 219-32-6549 MARYLAND 73 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 12945 FLETCHERTOWN ROAD 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1- Yes 2 NoNAVY Black White etc. þ Day 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK and Mental Hygiene. 3 X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) FUEL SUPERVISOR GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ OTHO JOHNSON SR. CORA WALLACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID JOHNSON JR./ SON 12945 FLETCHERTOWN ROAD BOWIE, MARYLAND 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State RESURRECTION CEMETERY 6/9/2010 CLINTON, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Suice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND 7474 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OR ONAR. disease or condition resulting in death) Medical Due to (or as a consequence of Examiner CUTE Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for as a consequence of sician and burial-transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown 1 Tes Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe death? 1 ☐ Yes 2 🏝 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death Certificate: 28a. Date of injury 28h. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number MDD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Cecil D. Corge
31. Date filed (Month, Day, Year) Suito 101A, Greenbeit, MI). 20770 MD. 7500 Hanover Parkwar

DHMH 17 Rev 7/2009

State

Registrar

JUN 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 June WILLIAM LEE **JOHNSON** 12:15p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country)
 CC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday, 8. Date of Birth (Month, Day, Year) 1 ፟ M 2 □ F Months Min 250-30-1989 **Director** Sep\_ Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1X Yes 2 No Washington 10e. Street and Number 10g. Citizen of What Country? r must be r 10f. Zip Code 1660 Ft. Davis St. 20020 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, traumatic event, the Medical Examiner was becedent ever in 0
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 1946—
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Baggage Handler Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မ General Lee Johnson Ida Belle Johnson 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3399 Highview Terr SE Washington, DC 20020 Mark D. Johnson - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1
Department of
Important: If if
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-17-2010 Triangle, VA. 4 Donation 5 Other (Specify) Quantico National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YTS Immediate Cause (Final Physician/ End Stage Ischemic Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Renal Failure wks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit End Stage Dementia Cause (Disease or iinjury yrs that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician to be detached for use as the burial Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe this certificate 1 Yes 2 No Les nospital or Attending Physician: The Yahours after death.

He Funeral Director. 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ဂ္ Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Director: d in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Supanich, RSM. MD D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, MD. RSM, MD Barbara Supanich,

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:58 p June 3, 2010 William Robert Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Davs Hours Min Feb. 19ay, Year 1944 North Carolina 237-64-1158 Director Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏲 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10803 Amherst Avenue, Apt. E 20902 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Narried White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Quality Control Technician Dental Supply aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. Jones Clara Bell Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10803 Amherst Avenue, Apt. E, Silver Spring, MD 20902 Kathleen Jones/Wife Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norbeck Memorial Park 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2010 Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, Md 20901 mª/fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Subdural Hematoma, Non-Traumatic Medical Due to (or as a consequence of) Examiner Coagulopathy Secondary to Coumadin Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Box in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown s been signed by the same should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à History of Ventriculo Peritoneal Shunt for Non-Obstructive 1 Yes 2 No 3 Probably 4 xt Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hydrocephalus, Cardiomyopathy page 2 s autopsy performed? 1 ☐ Yes 2 🔀 No Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 | No 욘 1 X Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this isjon of Attending Phy 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending Accident Suicide Investigation **Director:** 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 🔛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 065312 6/4/10 30. Name and address of person who complete Sudarshan Siva, MD ed cause of death (Item 23a) (Type, Print) 8600 Old George town Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Jones

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1230 laugh PM Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner ) a Me dical Cen IMOVE 0 If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** CT Min. (Month, Day, Year) 1 🔀 M 2 🗆 F Months Days Hours 045-54-8943 51 Director /31/1959 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Carroll MD Westminster 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 300 Robins Way 21158 USA items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ò 1X Never Married 2 Married Completed by Yes 2 X No 21215-0036 If Yes Give 1 ☐ Yes 2 √ No Specify: and Mental Hygiene. is marked other than "natural", Specify: white 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oermit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other thar Elementary/Seconday (0-12) College (1-4 or 5+) Health care Caregiver Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John M. Kallaugher Barbara Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Kallaugher, father 1255 Beggs Road, Westminster, Md. 21157 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Bartholomew's 6/8/2010 Manchester. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home Lenner 934 S. Main Street, Hampstead, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? 1 Yes 2 No Month Year signed by the a be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate To the Hospital or Attending Physician: I within 24 hours after death. To the Funeral Director, After this certifics completed filled in by the funeral director, t 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Division ☐ Accident ☐ Suicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🚉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Year

WIL

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

am

006029

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 4, Physician/ 2010 8:40A M Kogan Mary B. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 15309 Baughman Drive If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** May 15, Year 910 Days 1 □ M 2 ⋤ F Months Hours Washington, DC 577-09-8743 100 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20906 United States of America 15309 Baughman Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 24 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 X Widowed 4 Divorced Caucasian Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eva Hofnagel Abraham Bleicher 1 and 2 should b of Health and Mei item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1417 Castle Cliff Place, Silver Spring, MD 20904 Melissa Albaugh - Niece permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 06/06/201d Olney, Maryland Judean Memorial Gard. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 21. Signature of Eugeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Heart Disease Sequentially list conditions, if any Lecting to immediate cause. Enter Underlying ner Due to (or as a consequence of) Exami Chronic Renal Failure that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Dementia Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12-months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death the Division of Vital Records, P.O. þ signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires to 24 hours after death.
Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 3 E only one 29b. Signature and title of certifier 20 June 4, 2010 D0047330 Nowwo 30. Name and address of person who completed cause of death (Item 23a)-(Type, Print) 31. Date filed (Month, Day, Year) Dr. Thomas V. Joseph MD 50 West Edmonston Drive, Rockville, MD Registrar's Signature

Registrar

P.O. Box 68760 Division or Vital Records. ne Hospital or Attending P 124 hours after death. Ne Funeral Director: After t To the Hospital of within 24 hours at To the Funeral C

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 447 Physician/ Month GLADYS MAE LAIRD 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Moumica SA456UNA 8. Date of Birth (Month, Day Year, March 23, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 😾 F Hours 1929 Maryland Director 218-24-4916 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🕅 No Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21817 26288 W. Pear Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ⚠ No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Paintbrush Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Professional Hand Brush Maker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Ruby Adams Elwood Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27935 Phoenix Church Road - Marion, Maryland 21838 Diana Johnson (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunnyridge Memorial Park June 7, 2010 20c. Location - City or Town, State permit. Page 1 and Department of I Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crisfield, Maryland 4 Donation 5 Other (Specify) A Euneral 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. 9 Béth Crisfield, MD 21817 W. Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter Approximate shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a Unknown signed by t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မြ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After 1 5  $\square$  Pending 1 Natural 1 Yes Director: A 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours af

To the Funeral Di

completed filled in the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Sertifying Nurse Factioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 일 29b. Signature and tig 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year С. Lewis 1755 une 4,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rehaba Nursing Ctr.

6. Sex 7. Age (In year last birthday, lisbu lisburg Wicomico Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Davs Hours 2-6-1921 Director 89 213-16-8374 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating mast be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MDWicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Roger Street 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1942-Maryland 21215-0036 1 ☐Yes 2X No þ If Yes, Give Specify. White Specify. 3 X Widowed 4 ☐ Divorced 1945 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Salisbury Road Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ Harvey Lewis Ethel Timmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1037 N. Schumaker Drive, Salisbury, Maryland 21804 Vaughn Lewis - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-8-2010 Powellville, Maryland Powellville Cemetery : 21. Signature of Funeral Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complica slock, or heart failure. List only one this that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician en co M1 eny /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 120 Due to (of as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ №0 this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Maturai 5 ☐ Pending investigation death. 1 ☐ Yes 2 ∏No within 24 hours after death

To the Funeral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner state 29b. Signature and title-of-certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MiD. Registrar

Maryland 21215-0036

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#2&30, perMD, 6/16/10, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 1, 2010 Physician/ Month EL ・トトトヒ Medical 4a. Facility Name not institution. 4b. City, Town, or Location of Death Examiner 4c. County of Death 10NTGOMERY **SANDYSPRING** IENDS! URSING If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🛚 F Hours Min. NOWonth 200, Year 925 SOUTHY) DAKOTA 84 Director 504-16-5993 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 46 SHAW AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married ģ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) MEDICINE NURSING CONSULTANT 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MAGDELINA MORLOCH JACOB C. SCHAIBLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLE CT., SILVER SPRING, MD 20904 FRANK C. LENIHAN / SON permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN CREMATORY 06/07/2010 BRENTWOOD, MARYLAND 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. of Funeral Sen . Sign 11800 NEW HAMPSHIRE AVE., SILVER SPRING. MD 20904 MO1241 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .<del>Physicia</del>n/ HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION Sequentially list conditions, Examine Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi HYPERTENSION that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed FAILURE TO THRIVE 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv After this certificate 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 101 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 2, 2010 10 D31319

Registrar

State

Registrar's Signature

8218 WISCONSIN AVENUE, 305, BETHESDA, MD

Icreto Albiol, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN MILLER, MD,

31. Date filed (Month, Day, Year)
JUN 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MOUNE 2:00P M 2010 BARBARA W. LARSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's RENAISSANCE GARDENS Silver Spring 5. Social Security Number 579–18–2391 7. Age (In yrs. last birthday) 89 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Jan. 25, <sup>(ear)</sup>1921 Washington, D.C. Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f sho Examiner must be notified at Director Prince George's 1 🗆 Yes 2 🔁 No MD Silver Spring 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 20904 3160 Gracefield Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify "naturaf", Completed 3 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Vice Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Hilda Satterfield Norman Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Mercer Circle, Cambridge, MA 02138 Alvin Warren, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Metropolitan Crematory 6/08/10 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home,
4400 Powder Mill Rd. Beltsville, M 15 or 0 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 Years Immediate Cause (Final Alzheimers Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 r Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown þ Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2 😾 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 1 ☐ Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 🕅 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Owithin 24 hours after death.
To the Funeral Director: After to completed filled in by the funeral Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5  $\square$  Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 5 29c. License number 29d. Date signed (Month, Day, Year) 6/08/2010 D24093

State Registrar 3110 Gracefield RD. Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mark Parkhurst, M.D.

31. Date filed (Month, Day, Year) JUN 0 9 2010

5 2010

Physician/

1. Decedent's Name (First, Middle, Last)

Month June Joan 2010 Phyllis Lemon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Shady Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. 1277571931 78 Director 303-34-3721 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Silver Spring Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Dawn View Court 20904 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "I General Conference of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Accountant SDA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Frances Elizabeth Brenneman Eugene Herschel Fagala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14689 Oak Orchard Road. New Windsor. MD 21776 Elizabeth Zimmerman - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Lincoln Crematory: 06/09/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Fun ral Service Lic 22. Name and Address of Facility Simple Tribute & Cremation Ctr. 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INFARCTION Physician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Sue to for as a consequence of physician and the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has ral director, page 2 autopsy death? 1 Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No မ 1 🗌 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours a er death. Funeral Director After leted filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D 70144 10 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE MICHAEL MURRAY MEDICAL CENTER DR. MD 9901 31. Date filed (Month, Day, Year) Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > ( Certificate of Death

2. Date of Death

3. Time of Death

2240

10d. Inside City Limits

1 🛛 Yes 2 🗆 No

Montgomery

Country Indiana

Caucasian

nset and Death

48 HOURS

48 HOURS

Year

2010

U.S.A.

DHMH 17 Rev 7/2009

State

Registrar

JUN 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23 and 1, 91, 25 per me, 8905, 0 7/2 per me, 8905, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 2, Physician/ <sup>D</sup>2010 Phyllis 1 3 2 1 Mary Lohr 6:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** October 2, 1 □ M 2 💢 F Months Hours Pennsylvania Director 579-28-6334 T926 83 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Prince Georges Bowie Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12013 Tempo Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. "natural" 3 X Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Riggs National Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Bordner Herman Roosevelt Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12013 Tempo Lane, Bowie, Maryland 20715 Karen Annette Lohr-daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 June 7, 2010 Brentwood, Maryland Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Road, Laurel, Maryland 20707 Signature of Funeral Service Licensee m01234 h 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1 tracevelo Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leaving to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) DICAL EXAMINE attending physician and for use as the burial-transit executed CERTIFICATION APPROVED BY that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Year Pregnant at time of death 9 Unknown been signed by the Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coagulopathy Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) iner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Linpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practice on To the best of my knowledge distinctioned at the time date and clares, and due to the releasing and manner as wated 29b. Signature and title of a 29c. License number 29d. Date signed (Month, Day, Year) D0005879 2010

Registrar

DHMH 17 Rev 7/2009

Howard

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-04288 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lance Winfred Lewis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Lance Winfred Lewis Medical Examiner 0525 hrs June 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 216-78-9036  $_{1}X_{M}$ Months Days Hours Min Maury)Land 49 June 30, 1960 2 F Usual Residence of Decedent 10a State Ob. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Howard Laurel 1 Yes 2 XNo must be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9945 Naylor Avenue 20723 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Rece - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried White, etc. Yes White Yes 2 No specify Widowed Divorced Yes. Give Year Specify <u>გ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Superintendent Construction marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Be Lewis Valerie Stockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Dawn M. Lewis -wife 9945 Naylor Avenue Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State spartment of H Burial 2 X Cremation 3 crematory or other place! Removal from State Metropolitan Crematory 6/10/2010 Alexandria, Virginia Donation 5 Other Specify 21. Signature of Funeral Service Licenses 23 Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Exsanguination Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Ruptured esophageal varices complicating cirrhosis Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Division of Vital Records, P.O. Box 68760, in or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED line a-b, 27, per ME g904 6/23/10 TT signed by the attending physician be detached for use as the burial -IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 ✔ No 3 Probably 4 Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? ✓ Yes 2 1 V Yes No 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 Nursing Home 5 Residence 6 Other: this DOA 1 🗸 Yes ည After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Pending Yes 2 No To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. June 6, 2010 30. Name and address of person who completed cause of death (Item 23a)

Registra

Jack Titus MD.

State 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

**Deputy Chief Medical Examiner** 

32. Registrar's Signature

dorsera

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

eodore Mitche		State of Maryland / Department of State of Maryland / Department of Certificate of State of Maryland / Department of State of Sta	of Death		2010	13221
		egistrar	or Death	Reg. ?		3. Time of Death
Physicia	-	Decedent's Name (First, Middle, Last)		Month Da May 29, 2010		0414 hrs
'ical Exami		Theodore D. Mitchell  Ia. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Union Hospital	Elkton		Cecil	
			If Under 1 Year If Under 24Hrs	8. Date of Birth(N	MM/DD/YYYY) 9. Birth	nplace (State or
Funeral	-		Months Days Hours Min		Foreign	into()
Director		250-17-0320 <sup>1</sup> X <sup>M</sup> <sup>2</sup> F 48	frs.	April	<u>17,1962°°</u>	SC SC
		Usual Residence of Decedent 10a State 10b County 10c. City, Town or Loc	eation			10d. Inside City Limits
v an	ı	Tod. State				1 Yes 2 No
aryland 8a-f shovat once.	5	MD Cecil Warwi		100	Citizen of What Coun	try?
Maryland 28a-f show any d at once.	Director	10e. Street and Number	10f. Zip Code	Tog.		,.
the N		3 Rumsey Road	21912		USA	and Indian Block
with ns 23 be no	Funeral	Tr. Walter States	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Americ White, etc.	can Indian, black,
leath r iten	š	1 Never Married 2 1x xMarried 1 Yes 2 x No				Black
fter o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:			Specify: 6b. Kind of Business/Ir	
ours a	윙	15. Decedent's Education (Specify only highest grade completed)  16a. Decedenting	dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		D. Kind of business/ii	ildusti y
72 hc	eted	Elementary/Secondary (0-12) College (1-4 or 5+)				
036 ithin ne.	ompl	12	Mechanic	e (First, Middle, Mai	Automo	tive
5-0 ed wi	Ŝ	17. Father's Name (First, Middle, Last)				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medies	Be	Unknown	ling Address (Street and Number or	leretta	Mitchell State	Zin Code)
21 ould ould be man	ဥ	13a. Illiomant 3 Name / Classification (1) p 2 1 mm /				, 2.10 0000/
MD d 2 sho lth and n 27 is		Rose Hizotista (	Rumsey Rd, Wary	Date 2	20c. Location - City or	Town, State
		20a. Method of Disposition  1 Burial 2 XXcremation 3 Removal from State	r other place)		-	
Baltimore, permit. Pages I at Department of Hes Important: If ite		Haven (	Crematory 6	-17-101P	hester T	ownship,PA
nit. I artme	Ш	21 Signature of Euperal Service Licensee	2. Name and Address of Facility C	ongo Fun	eral Hom	e 0005
Dep July	0.1	21. Signature of Funeral Service Licenses Congo &C	P.O. Box 2593,	√ilmingt	on, DE I	9805
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Gunshot wound of right arm and	torso			Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, b				
	ner	if any, leading to immediate cause. Enter Underlying Cause				
	Ē	(Disease or injury that initiated				
red nsit	Ä	events resulting in death) Last  Due to (or as a consequence or).  d.				
50, te be executed nysician and burial - transit	ledical Examiner	UNPENDED AMENDED				
60, e be e ysicia		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
876 ificat ng ph	J/N	2 23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic preg	nancy	Month	Day Year
Sox 6876 leath certificate e attending phy for use as the l	icia	4 Pregnant at time of death 5	Other (Specify)			
Box 6876  e death certificat the attending ph ted for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	he wederlying cours given in Part I	23e. Did tob	acco use contribute to	the cause of death?
P.O.		Part II. Other significant conditions contributing to death but not resulting in t	the unidenying cause given in react.			bably 4 Unknown
res th				24a. Was ar		utopsy findings available
ords, P ow requires the sease signs of the sease si	eg			autops	y prior to	completion of cause of
e law e has ge 2 s	Completed			perform 1 Yes 2		es 2 No
tal Rectian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Chec	k only one)		
icett	8	examiner? Hospital: 1 Inpatient 2 V ER/Outpa	tient 3 DOA Other Nur	sing Home 5 🔲 R	Residence 6 Othe	er:
of VI Phys ter this		1 Ves 2 No  27. Manner of Death 1 Natural 5 Reading Unknown  1 Natural 5 Reading Unknown  1 Ves 2 No  28a. Date of Injury (Month, Day, Year) Unknown  Unknown  Unknown	e of Injury 28c. Injury at Work?	28d. Describe ho Subject shot	ow injury occurred	
on of Iding Pl th. :: After	<u> </u> [5	1 Natural 5 Pending Unknown Unknown Unknown	n 1 Yes 2 ✓ No	'-		
Sicological Attentages of the section by the	<u>[</u> [	2 Accident Investigation 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (St or Town, St	reet and Number or R	tural Route Number, City
Division of Vital Records, rat or Attending Physician: The law requirers after death.  In Jurecore: After this certificate has been seled in by the funeral director, page 2 should it.	Certification:	3 Suicide 6 Could not be determined (Specify) Car		90 Water Stree	et, Warwick, MD	
ospit hour hour	၂ ပ္	4 Momicide  29a. Certifier  Certifying Physician: To the best of my knowledge, death of the control of the cont	occurred at the time, date and place, a	and due to the cause	(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycomeleral filled in whe funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest	stigation, in my opinion, death occurre	d at the time, date a	and place, and due to t	the cause(s)
To T	8	and manner stated.  29b. Signatyre and title of certifier	29c. License number		29d. Date signed (M	lonth, Day, Year)
	-	6/11/1/1/1/	O.C.M.E.		May 29, 2010	
		30. Name and address of person who completed cause of death (Item 2 a)	- (			
	1	Zabiullah Ali, M.D. Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201		
l	State	22 Registrar's Signature				
Regi			racked		OCME	
DHMH 17 Rev 1		ORIG	INAL			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 23 = 25 M Paige Mears 2010 JUNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 41084100 KEGIONAL 8. Date of Birth (Month, Day, Year) 3-21-1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Security 1 🌠 M 2 🗆 F Months Virginia 230-42-7331 74 Director Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🗓 No MD Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 26845 Siloam Road 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married þ 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Salesman Furniture Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Nelson Mears Corvilla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26845 Siloam Road, Salisbury, Maryland 21801 Shirley Mears - Wife 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 6-11-2010 Oak Hill, Virginia 4 Donation 5 Other (Specify) Dowing Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or company shock, or heart failure. List only the ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician a the burial-t Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death bed by the side detached to q Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has by page 2 s performed?

Yes 2 No Hospital or Attending Physician: The 2 No 1 Tes 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) Be 2 **X** No Hospital: 1 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death

Natural

Accident

Suicide 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work?
1 Yes 2 No Division Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed Month Day, Year D3459 cause of death (Item 23a) (Type, Print) ARROLL St. SAlisbury Md State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE Day **JOSEPHINE** MADDEN REBA 1115 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, NORTH CAROLINA **Director** 239-54-8541 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX SELBYVILLE 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 36993 LAWS POINT ROAD 19975 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc δ 1 Never Married 2 X Married 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE 3 Divorced 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE AGENT INSURANCE 12 is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **HERMAN** CANADY HAZEL **ESTELLE** JORDAN RAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 36993 LAWS POINT, SELBYVILLE, DELAWARE 19975 CARL E. MADDEN/HUSBAND 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5- Other (Specify) DE VETERANS CEMETERY ! JUNE 10, 2010 MILLSBORO, DE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 11. Therefore the disease, or complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (ma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence oi). attending physician and Due to (or as a consequence of): The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 5 Other (specify) Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy the Hospital or Attending Physician: The hin 24 hours after death. the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No ı ☐ Yes Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury work Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Vit Vit Io 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, egistrar's Signatu State JUN 0 8 2010 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	1 - State of Maryland / Department / Depart	artment of Health and N tificate of Death		ene J. No.2 ()   ()	9560			
ľ	Physicia	n/	1. Decedent's Name (First, Middle, Last)  John Hamilton McAlister, III		2. Date of Death Month June	4 2010	3. Time of Death 4:15 A <sup>M</sup>			
	Medic Examin		4a. Facility Name (if not institution, give street and number)  DOVE HOUSE	4b. City, Town, or Location of Death Westminster		4c. County of Death				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 XM 2 IF 83 Yrs.	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8, Date of Birth	9. Birth Cou. 1926 Mary	pplace (State or Foreign ntry) 1 and			
	//aryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State  Maryland  Carroll County  Westminster				10d. Inside City Limits			
	vith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 1004 Washington Road	10f. Zip Code 21157		g. Citizen of What Cou nited Stat				
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 1 X Yes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	etc.			
Baltimore, Maryland 21215-0036	ithin 72 hour ene. r than "natu the Medical	Completed	(Specify only highest grade completed) (Give i	dent's Usual Occupation kind of work done during most of work O NOT use retired) SMAN	ing	Sales	ndustry			
and 2	be filed w ental Hygi ked other ic event, t	an l	17. Father's Name (First, Middle, Last)  John Hamilton McAlister, Jr.		e (First, Middle, Mai Thompson	iden Surname)				
Mary	12 should be file lith and Mental I 27 is marked o r traumatic eve			ng Address (Street and Number or Run Washington Road		ity or Town, State, Zip ter, Maryl				
more,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition  1	osition (Name of matory or other place) Cremation  June 20	Date 20 5, 10 H	Oc. Location - City or Tampstead,	· '			
Balt	permit. Departn Importa any injt		21. Signature of Funeral Service Licensee M01072 99	2. Name and Address of Facility El. 34 South Main Str	ine Funer	al Home stead, Mar	yland 21074			
<b>-</b> -	hysician/ Medical Examiner	ь	resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, b.	CER	or respiratory arrest		Approximate Interval Between Onset and Death			
760	cate be executed physician and the burial-transit	edical Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							
P.O. Box 687		Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   12   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   4   Pregnant at time of death 5   9   Unknown   12   Vision   13   Vision   14   Vision   15   Vision	☐ Ectopic pregnancy ☐ Other (specify)		23d, Date of deli Month	very Day Year			
s, P.O	res that th signed by d be detad	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		acco use contribute to the cause of death?				
Record	The law requi ate has been page 2 shoul	Completed			24a. Was an autopsy performe	prior to c ed? death?	opsy findings available ompletion of cause of			
Division of Vital Records,	nding Physician; th. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1				NDOVE NOVE			
Divisio	tal or Attending PP rs after death. al Director: After th led in by the funeral	al Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	he Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death of control only one 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	at the time, date and	place, and due to the o	ause(s) and manner stated.			
	117		29b. Signature and little of certifier	29c. License number  0067468		d. Date signed (Month	, Day, Year)			
	3+1VA		30. Name and address of person who completed cause of death (Item 23a) (Type, F	eat Westmuster, M	02/157					
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	books						

Medical completely within 2 To the I ٥ WSL IOTIVA

Hospital 24 hours

> State Registrar

29a. Certifier

29b. Signatur

nd title of certifie

JUN 08

and manner stated.

DHMH 17 Rev 1/200

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

STREET WESTMINSTE IND 21157

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Marylar		artment of H		Mental Hyg		110	10560
			Registrar  1. Decedent's Name (First, Midd	io I ast)		Ce	rtificate of L	Death		eg. No.		13007
Ш	Physicia			itchell					2. Date of Deat Month	6, Day 2010	Year	3. Time of Death 11:04 a M
	Medic Examin		4a. Facility Name (if not institutio	r Location of Death		4c. County		11:04 a M				
		•	Carroll Hosp	ice Dove Ho	use			minster			rroll	
	Funeral	-	5. Social Security Number	6. Sex 7 1  M 2  F		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Voor		lace (State or Foreign
	Director		579-12-6484 Usual Residence of Decedent	I L W Z XQ F	89	Yrs.	Working Buys	TIOUIS WIII.	May 21,	″°1921	Penn	Sylvania
	and <b>show</b> Lat	ō	10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Maryl 28a-f otifiec	Director	MD Prince	e George's		Adelph	ni					1 ☐ Yes 2 🙀 No
	a or 2	al Di	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Coun	try?
	th with ms 23 must	Funeral	1604 Merrim				207	83		USA		
<b>'</b>	or iter	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li></ul>	12. Was Deceder Armed Forces	3?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America	
ဗ္ဗ	s afte ral",	q pe	3 ☑ Widowed 4 ☐ Divorce				I ☐ Yes 2🙀 No	Specify:		Specify:		ite
Maryland 21215-0036	2 hour	Completed		ent's Education est grade completed)			dent's Usual Occupa kind of work done o		·	16b. Kind of Bu		
12	thin 73	mo;	Elementary/Seconday (0-12)	College (1-4 o	or 5+)	life. D	O NOT use retired)	iuring most or work	ing			
Ω Q	ed wil	Be	12 17. Father's Name (First, Middle,	l asti	<del></del>	Home	<u>maker</u>			own ho		
<u>a</u>	be file ental ked c	٥	Hugh McHenry	Lusty					e (First, Middle, M 1 <b>Monagh</b> a	,		
ary	hould and M s mai		19a. Informant's Name/Relations	hip (Type, Print)	_	19b. Mailir	ng Address (Street a	-			ate Zin Ci	nde)
Σ	nd 2 sealth an 27 i		H. Kenneth Mite	chell, Jr.	son		Full Moor		<i>lancheste</i>		2110	· ·
ore	e 1 ar : of He if iter or oth		20a. Method of Disposition  1	3 Removal from Sta	20b. P	lace of Dispo	sition (Name of natory or other place			20c. Location -	City or Tov	vn, State
Baltimore,	t. Pag tmeni tant: ijury o		4 Donation 5 Other	Specify)		roll (	remation	Inc $6/8$	3/2010 H			
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Egneral Service	Licensee		22	. Name and Addres	s of Facilit <b>Prit</b>	ts Funer	al Home	& C	hapel, PA
		$\dashv$	23a, Part 1, Enter the disease, or	complications that caus	ed the death	4	12 Washi	naton Rd.	Westmi	nster.	MD	21157
-	nysician/	ļ	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one car on each li	Pe. Car	STIV	E he	<b>10</b> 1	Prico	12=	Dis.	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Le to (or a	s a consequ		0 100	ADI	MICO	<u> </u>	_	
	Examiner		Sequentially list conditions,	· AO	RT	10	STEN	24201				
_	7 ±	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequ	ence of):						
	ecute and -trans	ixa	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or a	s a consequi	lence of:					$\perp$	
	icate be executed physician and s the burial-transit	edical	resulting in douting Last		o a concoqu	ichico dij.						
2/60	ficate g phys	Jedi		d								
8	ding Physician: The law requires that the death certific. h. Affer this certificate has been signed by the attending funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar	ncy	Ectopic pregnancy			23d. Date	of deliver	v
Box 68	death	sici	in the past 12 months?  1 Yes 2 No	4 Pregnant	at time of d		Other (specify)			Mon	th E	Day Year
л. О	at the		g ∐ Unknown Part II. Other significant condition			ulting in the un	dorlying agus give	on in Dort I	T			
ν. σ.	res tha	d b	at ii. Ottor significant contains	one contributing to death	but not rest	aiding in the di	idenying cause give	en in Pari I.				cause of death?
Ö	requi	lete										
Vital Records,	e has	Completed							24a. Was an autopsy perform	pr		sy findings available pletion of cause of
<u> </u>	an: The tifficat tor, pa		25. Was case referred to medical				26 Pla	ce of Death (Check	1 🗆 Yes 2		Yes 2	□No
	nysicia nis cer direct	9 P	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆 I	ER/Outpatien	Other	r:	me 5 Residen	ce 6 Other	(Specify)	Hospice
0	ing Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of inj	iury	28b. Time of injury	28c. Injury work?	at 2	28d. Describe how			FILISPICE
101	ttendi death tor; A the fi	Certificate:	2 Accident Investig	gation			M 1 □ Y	∕es 2 □ No				
DIVISION	after Direc		4 Homicide determ	ined 28e. Place of In building, e	ijury - At hor tc. <i>(Specify)</i>	ne, tarm, stre	et, factory, office		28f. Location (Stre City or Town, S		or Rurai F	oute Number,
ַ	spita hours neral d fillec	<u>ख</u> ⊦	29a. Certifier 1 Certifying	Physician: To the best of	of my knowle	edge, death o	ocured at the time.	date and place, and	d due to the cause	(s) and manner	as stated.	<del>i</del>
	In the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Uneck Z   Medical E	xaminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my oninior	death occurred at	the time date and	nlace and due t	o the cause	o/c) and manner stated
_		2	29b. Signature and title of certifier	1/ 00-	>		29c. License			d. Date signed (		
	WIL		+ our	kung			776	7 7 7	2	6		- 10
	8	3	30. Name and address of person v	who completed cause of	death (Item	CI			) <sub>11</sub> 50			
	State	3	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	ire	Worthing	ter Mue	) J			
	Registra	_	JUNOS	2010		A So	rekel					
			5-11-4-6	HUIU /		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010. Physician/ Month JUNE KARL S MANWILLER JR 6:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 200-22-4329 1 ₺ M 2 🗆 F Hours April 16, 1928 Director 82 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a Funeral 7351 Willow Road, Cottage 5 21702 United States of America death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 \( \subseteq No \) 1952-Black, White, etc. 1 Never Married 2 X Married within 72 hours after o δ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 1955 Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working id Mental Hygiene. marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Educator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ၉ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Karl S. Manwiller, Sr. Dorothy Fisher 19a. Informant's Name/Relationship (Type, Print)
Manwiller
Evelyn Menwiller / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7351 Willow Road, Cottage 5, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 T Cremation 3 Removal from State June 6, 2010 Smithsburg Crematory 4 Donation 5 Other (Specify) Smithsburg, Maryland . Signature of Funeral Service Lice Reeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ min Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or impury that initiated events. Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death ped significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one rentlying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number

D005506 |

State Registrar

ISTIVA

West Ninth Street; Frederick, MD 21701

ause of death (Item 23a) (Type, Print)

Registrar's Signature

n who completed

Nag

d address of per

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Olivia P. Miller 2010 01:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Mitchellville Collington Episcopal Life Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min. Director  $\mathbb{C}$ 219-07-3514 88 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Mitchellville Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 10450 Lottsford Road United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Peek, Sr. Anne Zebley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2962 Marine Circle, Stillwater, MN 55082 Lee A. Miller, III / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Episcopal Cemetery June 12, 2010 Upper Marlboro, MD 21. Signature of Funeral Series Vicensee 22. Name and Address of Facility Lee Funeral Home Calvert, F.A. Lisa M. Whits 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. in tauchion Onset and Death Immediate Cause (Final Pnysician/ MYOCAUdial disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** cardion chemic Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria -24ews Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by active to thrive 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Carcinoma adder 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
Tone 9th, 2010

State Registrar

dew

31. Date filed (Month, Day,

pper Manibovo

Name and address of person who completed cause of death (Item 23a) (Type, Print)

hampalous

32. Registra s Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death May 25, 2010 Year **Physician** Teresa MacDonald Rosa 9:44am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 26 South Duke Street Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 / 3 0 / 1 9 2 7 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🖺 F Months Days Hours 579-70-3772 Cuba Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at Rockville 1MYes 2□No notified MD Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 20850 26 South Duke Street USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Cuban Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laundry Worker Hotel marked other traumatic event, Uth and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor MacDonald Irene McKensei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26 South Duke Street Rockville, Md 20850 permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is any Injury or other trans Jeanette Rodriquez/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven 6/04/2010 Silver Spring, Md 5 ☐ Other (Specify) 4 □ Donation 21. Signature of PHINT PO ADMINISTRATION FUNERAL SERVICE, P.A. ineral Service License 9241 Columbia Blvd.Silver Spring, Md 20910 23a. Part1. Enter the orse se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear in ilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ischemic heart disease 10yrs /Medical Due to (or as a consequence of): **Examiner** 30yrs Atherosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: use lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. the a∏tJnknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetes mellitus type II 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed parkinson's disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 The performed? Yes 2 1 No certificate stroke 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ျ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No death 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 June 3,2010 D35055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mose Bonelli M.D. 8807 Colesville Road Silver Spring, Md 31. Date filed (Month, Day, Year) 82. Registrar's Signature

State Registrar

2010

JUN 08

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2010 Thelma Gertrude Mueller 4:46a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 75 Bryants Nursery Road Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min. July 02. 1914 269-03-4177 New Jersey Director 95 Usual Residence of Decedent 28a-f shov 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 75 Bryants Nursery Road 20905 U.S.A death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify. Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Walter Toot Katherine Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Mueller - Son Page 1 and 2 Bryants Nursery Road, Silver Spring, 75 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State injury 06/12/2010 | Cincinnati, Ohio 4 Donation 5 Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licens-le No #10 70 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Naman 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 MONTHS Immediate Cause (Final Ph sician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify, Certificate: To 1 🗆 Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accius 3 Suicide 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

State Registrar 3929 Ferrara Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2010

George Sengstack,

31. Date filed (Month, Day, Year)

D0012121

Wheaton, Maryland 20902

June 07, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 08. 2010 Year Phyllis Jane Meyer 1:40 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 14418 Barkwood Drive Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛣 F Months Days Hours washington. 02/07/1943 Director 579-56-4836 67 Usual Residence of Decedent fshow "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Rockville Montaomeru 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14418 Barkwood Drive 20853 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Completed 3 Widowed 4 Divorced Specify White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Computer Instructor Government Contracts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles E. Barsku Frances Brick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Meyer - Spouse 14418 Barkwood Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grdns: 06/10/2010 | Olney, Maryland 21. Signature of Funeral Service Li ens eMo #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Ph sician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) been signed by the atter should be detached for u in the past 12 months? Pregnant at time of death Month Day Year 2 🗶 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: All completed filled in by the fu

Baltimore, Maryland 21215-0036

29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 29d. Date signed (Month, Day, Year)

D42452

June 08, 2010

30. Name and address of person eted cause of death (Item 23a) (Type, Print)

Chitra Rajagobal MD 9715 Medical Center Drive, #221, Rockville, Maryland 20850

State Registrar

Medical

၉

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Susie Magrogan 4:30 A M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Friends Nursing Home Sandy Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Aug. 24, 1913 Mary land 96 579-90-4208 Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Sandy Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20860 USA 17340 Ouaker Lane 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Tennison Charlotte George Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Falling Creek Court, Silver Spring, MD 20904 Paula M. Decima, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 6/11/2010 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses R. Name and Address of Facility ardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD 20705 150 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗌 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1 Yes 2 🗆 No ☐ Accider☐ Suicide Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day,

Christopher J.

18111 Prince Philip Dr.,

who completed cause of death (Item 23a) (Type, Print)

Mays,

D39793

Olney,

June 8, 2010

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ JIMMIE LEE MCNEAL June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson 8. Date of Birth
6/5/193 9. Birthplace (State or Foreign Country) MISSISSIPPI Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Days Months Hours 354-28-2649 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Tes 2 X No MD. Harford Jarrettsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a 2806 Sharon Road 21084 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever (1005) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 21215-0036 If Yes, Give Year or Dates Black "natural", 3 Widowed 4 Divorced 1965 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurants Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental marked မ Clarence McNeal Martha Davis and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other tran Mildred K. McNeal (Wife 2806 Sharon Rd. Jarrettsville Maryland 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 21, 4 ☐ Donation 5 ☐ Other (Specify) Forest Cem Owings Mills. Ga ison 22. Name and Address of Facility E.G. a of Funeral Septice Lidensee Kurtz & Son Funeral dex P.A. Jarrettsville, Maryland Home, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on e in life. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final Physician/ 15 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Film Injurying Examiner Due to (or as a consequence of): detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Hospital: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifi 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE,

DHMH 17 Rev 7/2009

State Registrar WELLSSAU

31. Date filed (Month, Day, Year)

6701 N.C

32. Regist ar's Signature

HARLES ST.

10-04	541
Larry	McSherry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	n/	Registrar  1. Decedent's Name (First, N	/liddle,Last)	<del> </del>				2. Date of De Month		3. Time of Death
Medical Examir	ıer				y Micha			June 15,	2010 4c. County of De	1542 hrs
		4a. Facility Name (if not insti 66 North Main Stre	· =	number)			Town, or Location of hsburg	or Death	Washington	
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last birtho	lay) If Uno	der 1 Year If Unde	er 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9.	
Director		219-74-5800 Usual Residence of Decede	1½ M 2 F		51	Yrs. Mont	hs Days Hours		29, 1959	reign Country) Maryland
w any	Ì	10a. State 10b. Cou		100	c. City, Town or	Location			<del></del>	10d. Inside City Limits 1 y Yes 2 No
daryland 28a-f show 1 at once.	ģ	Maryland W	<i>ashington</i>				thsburg	<del></del>	10g. Citizen of What C	
th the Maryland 23a or 28a-f sho notified at once.	Director	112 Patric	dela Count			101. 21	21783			
with th		11. Marital Status	12. Was D	ecedent Eve	er in U.S.		ent of Hispanic Orig	gin? ( Specify Yes or N		nerican Indian, Black,
death or item	Funeral	1 Never Married 2	Married Armed	Forces?	No	If Yes, spec	ify Cuban, Mexican	, Puerto Rican, etc.)	White, etc	S.
s after ral", o	형		Divorced If Yes, Give Y or Dates:	ear			No specify:			White
2 hour	ted	15. Decedent's Education ( Elementary/Secondary (0)		(1-4 or 5+)			Occupation (Give orking life. DO NOT		16b. Kind of Busine	ss/industry
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	Ziomomai, roccondar, (c	4	(, , , , ,		Sales	Agent		Insu	rance
		17. Father's Name (First, Mic						's Name (First, Middle		
2121 vuld be fil Mental I marked c event,	To Be	19a. Informant's Name/Relat	erman McSh	erry	19b.	Mailing Addres	and the second second	A <i>nna Mae M.</i> ber or Rural Route Nu	ITTEL  imber, City or Town, St	tate. Zip Code)
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	7	Tracy S. M		(Wife,	1.0	-	•		rg, Marylai	nd 21783
Te, Te l and l Healt fitem		20a. Method of Disposition  1 Burial 2 X Crem		fram Chata	20b. Place of		me of cemetery,	Date June 18,	20c. Location - City	or Town, State
Pages Pages nent of ant: I		4 Donation 5 Other		nom state			ematory	2010	Smithsbu	urg, Maryland
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If iten 27 is unjury or other traumatic		21. Signature of Funeral Ser	1	٠,	MO 14 14		Address of Facility	U.L. Da	vis Funeral	
Physician	4	23a. Part I. Enter the disease	ee JW		death. Do not					Approximate Interval
/M_dical Examiner	1	failure. List only one ca Immediate Cause (Final disc or condition resulting in dea	ease a. Contact C			ead				Between Onset and Death
		Sequentially list conditions,	b							
	ije	if any, leading to immediate cause. Enter Underlying Ca		a conseque	ence of):					
rted d ansit	Examiner	(Disease or injury that initiat events resulting in death) L	ed During (an ar	a conseque	ence of):					
), be exect sician an urial - tr	dical	UNPENDED	AMENDE	)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the 1 Live 4 Pre	birth gnant at time	of pregnancy 2 [ e of death 5 [	Fetal death		pregnancy	23d. Date of deliv	very Day Year
D. Boy trhe deatl by the att	Phy	Part II. Other significant co	19 011	nown to death bu	t not resulting i	n the underlyin	g cause given in Pa	irt I. 23e. Did	tobacco use contribute	to the cause of death?
, P.O.	ব								es 2 🗸 No 3 🗌 F	Probably 4 Unknown
ords, aw requir	Completed	i						24a. Was auto	ppsy prior	autopsy findings available to completion of cause of
Reco	Ē							1 <b>✓</b> Yes	ormed? death 2 No 1 ✓	
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to me examiner?	dical Hospital: 1				26.Place of Death		1	
Physical this	의	1 ✓ Yes 2 No 27. Manner of Death		Inpatient te of Injury		ne of Injury	28c. Injury at Work	Nursing Home 5 28d. Describe	Residence 6 1 Ot	ther: Scene
Division of N pital or Attending Ph ours after death. teral Director: After t	Certification:	1 Natural 5	Pending Jun 1	th Day Year) , 2010	1530 l		1 Yes 2 🗸	Subject ch	ot self	
Division Hospital or Attent 24 hours after death Funeral Director:	iiig	3 V Suicide 6	Could not be	ace of Injury	- At home, farn	n, street, factor	y, office building, et	c. 28f. Location or Town,		Rural Route Number, City
Spital nours a neral 1	हैं।	4 Homicide		y) Sport/				66 North Ma	in Street, Smithsbur	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	<u>ica</u>		ng Physician: To the b Examiner: On the basi	s of examina						
To the within. To the comple	Medical	29b. Signature and title of ce	and manner entifier	stated.		29	c, License number		29d. Date signed (	Month, Day, Year)
		Part 6	~	51	20		O.C.M.E.		June 16, 2010	
	+	30. Name and address of pe				444.5	01 5	MD 04004		
		Russell Alexander		Medical l Registrar's S		111 Penn	Street, Baltimo	ore, MD 21201		
Sta Regist		31. Date filed (Month, Day, Y	2 2010 2	agistidi s S	rigitatule	and a	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John L. Neff June June 2010 6, 10:10 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5592 Teakwood Court Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year, une 22, 1 🗷 M 2 🗆 F Months Days Hours Min Director 579-18-0359 87 <u>June</u> Montana Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 🏝 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5592 Teakwood Court 21703 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ★Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3<sup>™</sup> Widowed 4 □ Divorced Specify: White Year or Dates. 1943-45 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Broadcast Engineering Elementary/Seconday (0-12) College (1-4 or 5+) President and Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Boyd Neff Georgia Ellen Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Cascioli/Daughter P.O. Box 144, Clarksville, MD 21029 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\stackrel{\mbox{\scriptsize M}}{\sim}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State June 10 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Prancis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Dav Year 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 유 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature 29c. License number 1511

State Registrar Thouson

Hirenkumar Shah, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hama

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2010 Harry Dean Nunley 05:13 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 Funeral 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ Months Days Hours Director 228-52-5045 69 Virginia Usual Residence of Decedent 10b, County iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 Tr No Maryland Ceci1 North East 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 104 Old Log Cabin Road 21901 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 KM Arried Black, White, etc ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hand Molder Brick Refractory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Archie G. Nunley Vesta A. McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia A. Nunley / Spouse 104 Old Log Cabin Road, North East, Maryland21901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Note the Company of the Clase Methodist Cemetery Juneo9, North East, Maryland 21. Signatur Finer Lervice Livense 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death LUNG Physician NON SMALL CELL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician; The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Yes 2 No 1 ☐ Yes ≥ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

Registrar

State

NATHAN

31. Date filed (Month, Day, Year)

STREE)

SLKTONI

JUNE, 6,2010

MD

106

32. Registrar's Signature

BOW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMADEH

			1 - For State Registrar	State of Ma	aryland		nent of F cate of		and Mental F	lygier Reg. N	- C U I	0	957
в	Physic	ian	Decedent's Name (First, Middle, La	ist)					2. Date of Month		Day Y	ear 3.	Time of Death
	/Medi		POL		PARK				June	1,	2010	10	:45 A №
	Exami	ner *	4a. Facility Name (If not institution, given	,		4b.	City, Town, o		f Death	4	4c. County of		
	3		Alice Byrd Tawes 5. Social Security Number 6.5		ome e (In yrs. la	st hirthday) If U	Crisfi <sup>Jnder 1</sup> Year		24 Hrs. 8. Date of	Righ	Some		(State or Foreign
b	Funeral Director			1 M 2 M F	96		nths Days	Hours	Min. (Month, 12/26	Day, Yea	ar)	Country)	_
	ne Maryland 8a-f show otified at	ector	10a. State 10b. County Maryland Somer	set	10c. City,	Town or Location	sfielo	l				1	side City Limits
	th with the 23a or 2 ust be no	Funeral Director	301 Somers Cove	Apartments		10	of. Zip Code 2	1817		10g. 0	U.S.		
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ X Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 11 Yes, Give Year or Dates:			Decedent of H specify Cub es 2 No	lispanic Orig an, Mexican Specify:	gin? (Specity Yes or , Puerto Rican, etc.)	No-		American Ind White, etc. Whit	
Maryland 21215-0036	hin 72 hc e. an "natur Me.ical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)  College (1-4or 5	5+)	16a. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retired	ation during most d)	of working	16b.	Kind of Busin		
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nd	12 should be filed within 7 h and Mental Hygiene. r is marked other than "r raumatic event, the Mediaumatic event,	Be	17. Father's Name (First, Middle, Last	)					r's Name (First, Mide	dle, Maide	en Surname)		
yla	ould Men arke	2	Asa Crockett						ra Pruitt				
Mar	12sh hand 7isn traun		19a. Informant's Name/Relationship						r or Rural Route Nui	-			)
	1 and Health em 27		Gloria Howard (Da 20a. Method of Disposition	augnter)	20b. Pla	290 H1 ace of Disposition		ive -	Salisbury		D 2180 Location - Cit		tata
nor	Pages nent of H		1 🖾 Burial 2 □ Cremation 3 □		ce	metery, cremator yridge Men	y or other plac						late
Baltimore,	그 는 약 등		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Sum	<del></del>	ne and Addre		6/4/2010	_ Cr	risfiel	ra, MD	
B	permi Depar Impor any Ir		Robert H. Brad	dshaw, dy	4	Bra 306	dshaw W. Ma	& Soni in St	s Funeral Crisfi	eld,	MD 2]	1817	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	iplications that c 13 ed one cause on each lir a.  Due to (or as		ASCV	mode of dyir	ng, such as	cardiac or respirator	/ arrest,		Appr Inter Onse	roximate val Between et and Death
4		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a conseque	ence of):							
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a conseque	ence of):					-		
P.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □Pregnant at 9 □ Unknown	2 Fetal	death 3 □Ecto	pic pregnancy er <i>(specify)</i>	,		-	23d. Date o Month		Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions	ontributing to death bu	ut not result	ing in the underly	ring cause giv	en in Part I.			use contribu		se of death? 4 □Unknown
or Vital Records,		Completed							24a. W au pe 1 Yes	topsy rformed?	prio dea	or to completi	ndings available on of cause of No
Vit	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			J.DOA Othe		of Death (Check onl				
	Phys r this ral dii	은 :	1 Yes 2No 27. Manper of Death	28a. Date of Injur	rv 2	R/Outpatient 3[ 28b. Time of	J DOA	4 Nur	sing Home 5 Re		6 □Other (	(Specify)	
Division	Attending I r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year)	Injury M		yat k? Yes 2 □ N	ło		and Number	or Pural Pour	to Number
Οİ	i i i i		4 Homicide determined	building, etc	c. (Specify)				City or	Fown, Sta	ate)		e rvanibei,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	nysician: To the best on miner: On the basis of and manner sta	examination	on and/or investig	ation, in my o	pinion, deat	a place, and due to the time to the time.	ie, date a	and place, and	d due to the o	
	P P P	2	29b. Signature and title of certifier	1 40			29c. License		0	29d. D	Date signed (A		'ear)
Y,	T						De	f809	<u> </u>		611	12010	
			30. Name and address of person who	completed cause of de		(Type, Print)	11011	11 001	way (	300	£ . 0 1	mp	21817

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE SUNE Year 20/0 DORIS ROSALYN **PARKS** 1728 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death REGIONAL TENINSUM Center SH1164KL HICOMICO Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛱 F 231-40-6198 Months Days 09/02/1928 Director **VIRGINIA** Usual Residence of Decedent 10a. State 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director **VIRGINIA ACCOMACK TANGIER** 28a-f 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ŏ Completed by Funeral 23a 16216 MAIN RIDGE ROAD 23440 ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Tes 2 No Specify: 3 X Widowed 4 □ Divorced Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiried) HOMEMAKER 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC Be 17. Father's Name (First, Middle, Last)
CRANSTON L. MARSHALL 18. Mother's Name (First, Middle, Maiden Surname, EUNICE MARIE SHORES id Mental I marked o ပ t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
PAULETTE PARKS / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P\_O\_BOX 56. TANGIER. VA 23440 P.O. BOX 56, TANGIER, VA 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o TANGIER, VIRGINIA PARKS FAMILY CEMETERY 06/09/10 4 ☐ Donation 5 ☐ Other (Specify) WILLIAMS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 25046 PARKSLEY ROAD, PARKSLEY, VIRGINIA 23421 Ullamo 23a. Par 1. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ASCVD MONTHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s autopsy performed this certificate 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2. No 1 Tes ည 1.X Inpatient 2 DER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1. X Natural 5 Pending work? 2 🗆 No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical t 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) To the within To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 180E. CARROLL ST. SALISBURY, Md 21801 OSZ MD 32. Regist ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-04238 Molly Pritchard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 19575 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ **Medical Examiner** Molly A. Pritchard 2110 hrs June 3, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 7. Age (In yrs. last birthdav) 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director 130-42-0830 60 1950 1 M 2 X F Jan. 4. Country) New York Usual Residence of Deceden any 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Count 1 Yes 2 XNo or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than ".... Germantown Maryland Montgomery Director 10e, Street and Number 10f, Zip Code 10a. Citizen of What Country? 19313 Ridgecrest Drive 20874 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Insurance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William O'Connor Patricia George ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin R. Pritchard 19313 Ridgecrest Drive, Germantown, MD 20874 (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Metropolitan 1 Burial 2 Cremation 3 Removal from State June 6, 2010 Alexandria, Virginia Donation 5 Other Specify Crematory 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service Licenses much 10 East Deer Park Drive, Gaithersburg MD20877 Approximate Interval Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Hemopericardium Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Aortic Dissection Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö δ ۵ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: DOA 2 V ER/Outpatient 3 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury After Certification: 1 🗸 Natural Division 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 🙀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 4, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

arks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 2, 2010 11:40 A M WILLIAM JAMES PRICE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 5. Social Security Number . Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours OHIO Yrs Director Ĩ918 287-16-2860 91 Usual Residence of Deceden an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD MONTGOMERY KENSINGTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? death with IISA 10206 KENSINGTON PARKWAY 20895 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. 3 X Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) event, the FOUNDER / EXECUTIVE DIRECTOR WORLD PEACEMAKERS + Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည MARY L. WRIGHT LEWIS JAMES PRICE traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 10206 KENSINGTON PARKWAY, KENSINGTON, MD 20895 LEWIS C. PRICE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or of 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) LINCOLN CREMATORY 06/07/2010 | BRENTWOOD, MARYLAND Funeral Service Lic 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 MO1241 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ACUTE CARDIAC ARRYTHMIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a g Unknown P.0. Part II. **Other significant conditio**ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 XNo Other: ဂ္ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Il Director: After this od in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 🔲 Yes 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after thin 24 hours at the Funeral Dimpleted filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) မ JUNE 2, 2010 D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DRIVE, ROCKVILLE, MD 20850 SAYED EISAYYAU, MD,

State

Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Erasmo Antonio 2		I - For State	ate of Maryland / [	Department o Certificate o		nd Mental F	•	201	0 19577
Physicia Medical Examin	n/	Registrar  1. Decedent's Name (First, Middle  Erasmo	Antonio	7aldan:	Dort	-:110	2. Date of De Month June 6, 2	Day Year	3. Time of Death 1250 hrs
drag		4a. Facility Name (if not institution		Zaldan		cillo or Location of Deat		4c. County of	Death
		11558 Montgomery Ro			Beltsville	Less cons	- To p	Prince Ge	
Funeral Director		212-77-6386	6. Sex 7. Age (I	In yrs. last birthday) 20 <sub>Yrs</sub>	If Under 1 Ye  Months Da		_	3/1990	9. Birthplace (State or Foreign EduntrySalvado)
any		Usual Residence of Decedent  10a. State 10b. County		c. City, Town or Local					10d. Inside City Limits
<u> </u>	اق		e George's	Hyat	tsville	9			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.		10e. Street and Number 7117 Varnum	Street		10f. Zip Code 207	84	- 1	10g. Citizen of What El Sal	-
≥ S ≤	by Funeral		1 Yes 2 X If Yes, Give Year or Dates:	No If Y	es, specify Cuba $\mathrm{El\_S}$ :	lispanic Origin? (S an, Mexican, Puerto alvador o specify:	o Rican, etc.)	14. Race - , White, e	American Indian, Black, etc. White
nore, MD 21215-0036  ages 1 and 2 should be flied within 72 hours after death nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner must	Completed	15. Decedent's Education (Speci Elementary/Secondary (0-12) 1 2	College (1-4 or 5+)	during m		ation (Give kind of e. DO NOT use ref . erk		Depart	ment Store
MD 21215-0036 of 2 should be filed within 7 lits and Mental Hygiene. In 27 is marked other than an 27 is marked other than an article event, the Medical and a should be a sho	8	17. Father's Name (First, Middle, I Erasmo Anton	io Zaldana			Eva (	Georgi	Maiden Surname) na Porti	
MD 21 2 should h and Me 27 is ma martic ex	^[	19a. Informant's Name/Relationsh Eva Georgina		er 19b. Mailin	g Address (Stre 7 Varnu	et and Number or Im Stree	Rural Route Nu	mber, City or Town, ttsville	State, Zin Gode) 4 , Mary Land
Baltimore, MC permit. Pages 1 and 2 si Department of Health an Important: If item 27 i		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spe	7	20b. Place of Dispos Municip de Mona	sition (Name of co her place) al Ceme aua	etery <sub>6/</sub>	Date 13/201	20c. Location - C San M El Sa	ty or Town, State liguel, alvador
Balti permit. Departm Imports injury o		21. Signature of Funeral Service L	Legisee /	291	ame and boddie	SORTOWALD	OI FUNI	ERAL SER	VICE, P.A. ring, Md2091
Physician /M-gi-al		23a. Part I. Enter the disease, or c failure. List only one cause of							Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence						Death
	I e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	ence of):					
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o pe sici	edical	UNPENDED	AMENDED						
Ox 687( ath certifica attending pl		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at time	2 Fe	tal death 3 her (Specify)	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
s, P.O. Be irres that the de signed by the detached f	2	Part II. Other significant condition	ns contributing to death bu	ut not resulting in the u	inderlying cause	given in Part I.		tobacco use contribu es 2 V No 3	e to the cause of death?  Probably 4 Unknown
tal Records, cian: The law requir certificate has been s ector, page 2 should	Completed								re autopsy findings available r to completion of cause of th?  Yes 2 No
Vital Rec	e i	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatient		e of Death (Check		Residence 6 🗸	Other: Scene
on of Vit nding Physic th. r: After this		1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pendir	28a. Date of Injury FOUND: Day, Year)	28b. Time of I	njury 28c. Inju	ury at Work? Yes 2 ✓ No	-	how injury occurred	Janes George
Division ospital or Attend hours after death. uneral Director: y filled in by the f	ᄓ	3 Suicide 6 Could determ	not be	- 1247 hrs - At home, farm, stree	et, factory, office	building, etc.	or Town,		or Rural Route Number, City
ing par	. j		vsician: To the best of my kn	owledge, death occur			due to the cau	se(s) and manner as	stated.
	Me	29b. Signature and title of certifier	and manner stated.	4	29c. Licens	se number M.E.		29d. Date signed June 7, 2010	(Month, Day, Year)
	;	30. Name and address of person water Zabiullah Ali, M.D. A	who completed cause of death	1	n Street Balt	timore, MD 21	201		<u>, , , , , , , , , , , , , , , , , , , </u>
Stat Registra		31. Date filed (Month, Day Year)	2010 32/Registrar's S	,					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ARKer Nelson chael 2010 May 1:18 a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Forestville Nursing & Rehab Center Forestville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, 1 M 2 □ F Months Days Hours Min Sep 18, 579-64-0170 63 1946 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 ☐ Yes 2X No MD Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7420 Marlboro Pike 20747 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 X Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Parker Helen C. Holt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawna L. Cromwell-Snead-Dtr 615 Early Dr. Broadway, VA. 22815 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6-3-2010 | Alexandria, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland uluino 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death andio disease or condition resulting in death) Due to (or as a contequence of): organ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is itleded as to be continued to the continued Due to (or as a consequence resulting in death) Last Due to (or as a consequence of): Dialites mellilus IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No memi Severe 1 □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

Examiner

Funeral

Director

28a-f show

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"natural",

lal Hygiene.

traumatic event, the Medical

e cartment of Health and Mental Hy moortant; If item 27 is marked other my injury or other traumatic event, c. 2.

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Exeminer hust be notified at

Directo

Funeral

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Completed

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/Medical

burial-tran attending physician for use as the buria signed by the a t be detached for should I page 2 s certificate director. After this funeral after death filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by Be Medical Certification: To

25. Was case referred to medical examiner? 27. Manner of Death 1 Natural
2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature a title 29c. License number D 51520 29d. Date signed (*Month*, *Day*, *Year*)

ss of person who completed cause of death (Item 23a) (Type, Print) Southern Ave- SE #310 Washington, Dc 20032

and manner stated.

Ad M.D. JUN 0 9 2010

State Registrar

24 hours

completely within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland			nt of Ho te <i>of D</i> o		Mental H	ygiene Reg. No	.2011	19579
			Decedent's Name (First, Middle, L.)	ast)						2. Date of D	eath		3. Time of Death
	Physicia Medic		IRIS	PATRICA	PEN	DERGRA	SS			JUNE	7	2010 <sup>Year</sup>	8:05 A M
	Examin	er	4a. Facility Name (if not institution, gi PRINCE GEORGE *					, Town, or L IEVERL	_ocation of Death _Y			:. County of Deat RINCE GE	
	Funeral		5. Social Security Number 6. 399–14–2104	1 DM 2DXE		st birthday) Yrs.	If Undo		If Under 24 Hrs. Hours Min.	8. Date of E (Month, L JAN 25	lirth Day, Year)	9. Bird	thplace (State or Foreign untry) SCONSIN
	Director		Usual Residence of Decedent	8	16	115.				JAN 25	, 194	24   WIS	CONSIN
	yland •f sho ed at	ctor	10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits  1 Yes 2 □ No
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036	within 72 hours after death with the Maryland giene. Her than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?		If	Yes, spe		panic Origin? (Sp , Mexican, Puerto Specify:		D-	14. Race - Ame Black, White Specify: Wh	
21215-0036	Than than e Me	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	Education	+)		ind of we NOT us		tion Iring most of wor	king		Kind of Business	Industry
nd 2	permit. Page 1 and 2 should be filed witt Department of Health and Mental Hygie Imp. rtaxt: If item 27 is marked other ranny injury or other traumatic event, th 9/56.	To Be	17. Father's Name (First, Middle, Last	")		WALIN	LOD	- 1	18. Mother's Nar				
Maryland	ould be id Men marke matic	-	EDWARD MERBAEK  19a. Informant's Name/Relationship			10b Mailin	a Addres		GLADYS	YOUNG	her City o	r Town, State, Zij	a Code)
Σ	d 2 sh alth ar alt is r 27 is er trau		PHILLIP PENDERGR				_	HAPEL					AND 20743
ore	e 1 an t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3		CE	lace of Dispos emetery, crem	atory or	other place,	)	Date		ocation - City or	
Baltimore,	iit. Pag irtmeni rtavt: njuri		4 Donation 5 Other (Spe	cify)	RIV	ERDALE				/2010 B TE		VERDALE, S FUNERA	MARYLAND
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	Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line		n. Do not ente		de of dying,	, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a									
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	ate be executed physician and the burial-transit	al Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of):							
9	icate b physics the c	ledical		d									1
Box 68	law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	23c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal	Ideath 3	Ectopic Other (s	pregnancy specify)			.	23d. Date of de Month	livery Day Year
s, P.O.	res that th signed by d be detac	by	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the u	nderlying	cause give	en in Part I.				the cause of death?
Vital Records,	sician: The law requi certificate has been irector, page 2 shoul	Completed								_ pe	as an topsy rformed? s 2X 1	prior to death?	topsy findings available completion of cause of
ē	sian: T ertifica ctor, p		25. Was case referred to medical examiner?						ce of Death (Che		5 <u>5</u> 7 <u>1</u>		
₹	Physic this or al dire	은	1 ☐ Yes 2X No  27, Manner of Death	Hospital:  1 X Inpatie  28a. Date of injur		ER/Outpatien 28b. Time of	t 3 🗆 [	Other 28c. Injury	4 ☐ Nursing F	lome 5 Re		6 Other (Spec	cify)
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Division of	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc	. (Specify)					City or T	own, State	e)	ral Route Number,
	e Hosp 124 hou e Fune	Medical	(Check 2 Medical Exa	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination	and/or invest	igation, ir	my opinion	n, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
	To the comp	2	29b. Signature and title of certifier	7				c. License			29d. D	ate signed (Monti	h, Day, Year)
				naiN		00-1/7	-i#\	D00	69669		0	6/07/	9010
2	6		30. Name and address o∜person who ANUPAMA NEELAK					RIVE	CHEVERLY	,MARYL	AND :	20785	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	's Signa	ure was							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	ate of Marylar		artment of F tificate of L			giene Reg. No.	0 19580
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	· 101				2. Date of Dea	ath	3. Time of Death
	Medic Examir	cal	Catharine Prent  4a. Facility Name (if not institution, give street)		er	4b. City, Town, or	Location of Deatl		1 <sup>25</sup> , 20°	
ار	<i>/</i>		103 West 2nd Street			Frederic			Frederi	ck
١	Funeral Director		5. Social Security Number 6. Sex 1 M M	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Day Feb. 23	, Year) 924 W	Birthplace (State or Foreign Country) ashington D.C.
	show dat	ξ	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	Maryland Frederick	Fre	derick	Lieu en e				1 🏋 Yes 2 □ No
	with th	Funeral [	103 West 2nd Street			10f. Zip Code 21701			10g. Citizen of Wha United St	
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	٥	1 Never Married 2 X Married 1	as Decedent Ever in U. med Forces2. ☐ Yes 2 XNo Yes, Give ear or Dates.	If	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. hite
15-0	72 hou n "natu ledica	Completed	15. Decedent's Educatio (Specify only highest grade con	npleted)	(Give k	ent's Usual Occupa	ation during most of wor	king	16b. Kind of Busin	ess Industry
212	within giene. er tha , the N		Elementary/Seconday (0-12) Co	ollege (1-4 or 5+) 5+	1	o NOT use retired) emaker			Own Home	
Maryland 21215-0036	be filed ental Hy <b>ked oth</b> ic event	To Be	17. Father's Name (First, Middle, Last) Louis W. Prentiss				18. Mother's Nar Helen Bo		Maiden Surname)	
<b>fary</b>	should and M is mar raumat		19a. Informant's Name/Relationship (Type, Pri	,		g Address (Street a	and Number or Ru	ral Route Number		
ē,	1 and 2 f Health item 2 other t		Walter Plummer (hus) 20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	1	rederic.	K, Mary La	nd, 21701
			1 $\square$ Burial 2 $X$ Cremation 3 $\square$ Remove 4 $\square$ Donation 5 $\square$ Other (Specify)			atory or other place g Cremato		18,201	0 Smithsb	urg, Maryland
Balt	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	MO1612	Ke 10	Name and Address eney & Ba 6 East Cl	asford P. nurch St.	A. Fune Freder	ral Home ick. Marv	land 21701
			23a. Part F. Enter the disease, of complication shock, or heart failure. List only one caus	ns that caused the deat se on each line.						Approximate Interval Between
=F	hysician. Medical	1	reculting in death)	Pseudobulba Due to (or as a consequ		у				1 Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions, b. —							
	ted   	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Dus to for as a sonsequ	ienice Oij.					1
	icate be executed I physician and s the burial-transi	al Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequ	uence of):					
9	icate be physic s the bu	ledical	d		_					
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. completed birector. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		in the past 12 months?	/es, outcome of pregna ☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of c ☐ Unknown	aldeath 3 🛄	Ectopic pregnance Other (specify)	у		23d. Date o Month	f delivery Day Year
7. O	s that th gned by be deta	by Pł	Part II. Other significant conditions contribut	ing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.			te to the cause of death?
ras,	require	ompleted	Hypertension Vascular Parkinson	iem						Probably 4 Unknown
Division of Vital Records,	Physician: The law this certificate has t al director, page 2 s	Compl	Vascatar rarkinson					24a. Was a autop perfor	sy prior deat	e autopsy findings available r to completion of cause of h? Yes 2 □ No
Ital	ician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospita	l:		Othe	ace of Death (Chec	k only one)		
0 0	ng Phys ter this neral di	te: To	27. Manner of Death 28	1 Inpatient 2 a. Date of injury (Month, Day, Year)	ER/Outpatient 28b. Time of injury	28c. Injury	4 ∐ Nursing H at		ence 6 Other (Sow injury occurred	pecify)
Sion	ttendir death. ctor: Af / the fu	Certificate:	1 ▼ Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	e. Place of Injury - At ho		M 1 🗆	Yes 2 No	201  + 12		Devil Devile Mumber
	To the Hospital or Attending Physician: The k within 24 hours after death, to the Funeral Director: After this certificate his completed filled in by the funeral director, page		4 - Hornicide determined	building, etc. (Specify	)			City or Town	n, State)	Rural Route Number,
:	le Hosp n 24 hou le Funer	Medical	29a. Certifier (Check only one) Certifying Physician: 3 Medical Examiner; On 3 Certifying Nurse Pract	the basis of examination	n and/or investi	gation, in my opinio	n, death occurred a	it the time, date ar	nd place, and due to	the cause(s) and manner stated.
	vithir Comp		29b. Signature and title of certifier	D		29c. License	number	1	29d. Date signed (M	onth, Day, Year)
			30. Name and address of person who complete	Le u / C		D09689	9	þ	une 16, 2	010
			Austin Pearre 300 We	st 9th Stre	eet, Fr		Marylan	d, 21701		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure d.	barker				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0 2010 /Medical County of Death Facility Name (If not institution, give street and number, Town, or Location of Death Examiner NEUSIU W1451 House E OWEL eu If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Days Country) El Salvador 1 1 M 2 □ F 225-51-8345 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐Yes 2 XNo Item 27 Is marked other than "natural", or items 23a or 28a-f slother traumatic event, the Medical Examiner must be notified Maryland Howard Fulton Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code El Salvador 12215 Lime Kiln Lane 20759 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 Specify: Spanish 11∏ Yes 2□ No Specify: Spanish 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Stocker Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Idalia Rivera Jose Antonio Castro ည and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is no any injury or other traun 12215 Lime Kiln Lane, Fulton, Maryland 20759 Melissa Valladares- Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Balt/Wash Crematory June 6, 2010 | Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee <sup>2</sup>Fleck Funeral Hone, INC. MIA 10123 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on seen line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MICH 91 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death مراة t not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2☐ No 3☐ Probably 4☐ Unknown ate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

within 24

a2/04 31. Date-filed (Month, Day, Year) State JUN O

29b. Signature and title of certifie

Hickory Rids e Rd Columbis Md 21044 10805 Aegistrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marilin Ruth RUBINSTEIN June 8, Physician/ 2010 6:17 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** New York 1 D M 2X F Aug. II Director 77 064-24-8789 Usual Residence of Decedent and Mission some and Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show marked other than "defical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director Silver Spring Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3310 N. Leisure World Blvd., #822 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 ☐¥Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ...ge 1 and 2 should be uppartment of Health and Menta. Important: If item 27 is markany injury or other: Pauline Abramsky Louis Sosnow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Snowfall Way, Westminster, MD 21157 Eric Rubinstein, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 N Removal from State 4 Donation 5 Other (Specify) King David Memorial Garden 06/10/10 Falls Church, VA Sign f Funeral Service Licenses Torcmรีทร่ห์y⁵⁵Hébrew Funeral Home 254 Carroll St., NW. Washington. 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cancer of Unknown Primary Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Vear 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown ed by the a To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D0061937 20910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREST GLEN RD SILVERSPRING, ND CANDACE L. WILSON MI 31. Date filed (Month, Day, Year)

JUN 0 9 2 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 5, 2010 6:00 A Dorothy Rubin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Hebrew Home Of Greater Washington Montgomery Rockville 5. Social Security Number Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Days Hours Min. Months 082-01-6131 04/9013 9919913 New Jersev 97 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7100 Masters Drive 20854 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kattie Alperovitch Israel Abramowitz permit. Page 1 and 2 should be Department of Health and Men-Important. If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Rubin-Son 7100 Masters Drive Potomac, Maryland 20854 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🖾 Removal from State Riverside Cemetery 06/11/2010 Saddlebrook, NJ 4 Donation 5 Other (Specify 22 Name and Address of Facility anzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 Signature I Pineral Service L MU163 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, jer cause. Enter Underlying Cause (Disease or iinjury that initiated events Directo (or as minorsequence of) Exami and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? 1 ☐ Yes 2 ☐ No ours after death.

eral Director. After this certific filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 24 hours Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D005788 2016

Registrar

DHMH 17 Rev 7/2009

State

1801 E. Jefferson Street Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Damien J. Doyle, MD

2010

31. Date filed (Month, Day, Year,

JUN 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Marjorie W. Reiley 10:58 P.M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 19024 Oxcart Place Montgomery Village Montgomery 8. Date of Birth (Month, Day, Year) March I, 1920 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Months Days Hours Min. Ohio Director 201-03-6666 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If final 71 is marked other than "natural" ---any injury or other transmark. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20886 19024 Oxcart Place United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify If Yes Give Specify: Completed 3 Divorced 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Air Transport Assoc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ J. Williams Albert Dorcas Beegle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmond P. Reiley/Husband 9024 Oxcart Place, Montgomery Village, MD. 20886 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Souls Cemetery 6/10/2010 Germantown, Maryland ure of Funeral Service Liceve 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death month Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 months Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Year Pregnant at time of death Day the signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Chronic Obstructive Pulmonary Disease 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b Il director, page 2 sl autopsy performed' death? 2 🗌 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA this funeral nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Steven

MA

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Kariya,

09

10605 Concord Street,

D 36252

29d. Date signed (Month, Day, Year)

June 8, 2010

#500, Kensington, Maryland 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2<u>010</u> Alice Redd Month May 31 9:55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days 1 XM 2 □ F Hours Min. Year 62 223-68-5787 Director Yrs. June Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits DC Washington 1 Yes XXNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be 401 K Street Apt G2 Funeral 20001 USA Was Deceuc... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 10th College (1-4 or 5+) Housekeeper Self-Employed other traumatic event, Be 17. Father's Name (First, Middle, Last) 2 should be file h and Mental h is marked o Mother's Name (First, Middle, Maiden Surname) ဥ Henry Roberts Carrie Boyd 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maketa Redd/Grandaughter 401 K Street NW G2 Washington, DC 20001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Wylliesburg Cem. 07/12/2010 Wylliesburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service Licensee 20019 22. Name and Address of Facility Dunn&Sons 5635 Eads St.NE Washington, DC 23a. Park. Enter the disease, or complications that caused stock, or heart failure. List only one cause on each line he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician/ laute V disease or condition resulting in death) Mocardial Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Dav Year detached by the 9 XUnknown I)I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after Funeral Direc 4  $\square$  Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier or On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated that increase in the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examin 3 Certifying Ny To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055120 MI Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard Yahnen MD 1328 Jouthen avenue 310 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

JUN 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day June Physician/ 2010<sup>a</sup> Maria Rondel 22:05P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Dec. 31, 1919 Days Hours 1 □ M 2 🔀 F 90 212-41-0751 Russia Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important! If liem 27 is an arked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Rockville Maryland 1 🗌 Yes 2 🎗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 6121 Montrose Road 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Industry Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lyuba (unk) Anatoliy (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Cherie Down Lane Cape Canaveral, Florida 32920 Lyuba Khomutetsky -daughter 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns | 6/18/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Sersis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the 9 Unknown Hospital or Attending Physician: The law requires that the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No MARIA 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir After this 27. Manner of Death 1 X Natural 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending División 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) SONDEL determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) itle of certifier 29c. License number 29b. Signature and D068405 June 3, 2010 Ulwaya Nieto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus David Guevara-Nieto, 22. Register's Signature

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

arkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day ZIPM **Physician** tourse /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Carroll Westminster Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months Days Hours 214-28-0703 80 Yrs Sep 30, 1929 Maryland Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a f show any Injury or other traumatic event, the Medical Examiner must be motified at once. 10c. City, Town or Location 10a State 10h. County 1 ☐ Yes 2 X No Director Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6218 Taneytown Pike 21787 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: white þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Hobbs, Sr. Ruth Wivell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6224 Taneytown Pike, Taneytown, MD 21787 Catherine E. Engel, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 6/9/2010 St. Joseph Cemetery Taneytown, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. p. line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the ! IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

To the Hospital or within 24 hours a To the Funeral D MJL 10

Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated

29c. License number

139VOL91

29d. Date signed (Month, Day, Year)

East Main sheet westwinster HD 2/15,

			. For	e Type or Prii State of Ma		d / Departme					0	10500
			State     Registrar			Certifica	ate of D	eath	F	leg. No.	2010	19589
	Physicia Medic		1. Decedent's Name (First, Middle, La		ScH.	4117 -0	U74A	/	2. Date of Dead Month June 8	th Day	2010 Year	3. Time of Death
)	Examin	er	4a. Facility Name (if not institution, given 7228 Swansong Water)				ty, Town, or t Bethes	Location of Death		4c.	County of Death	
-	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. Ia	st birthday) If Un	der 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
	Director		577-06-1733 Usual Residence of Decedent	1 □ M 2 🔀 F	5.5	Yrs. Month	s Days	Hours Min.	oct 8,	195	4 Cou	France
	and show	tor	10a. State 10b. County		10c. City	, Town or Location						10d. Inside City Limits
	Maryl 28a-f	irec	Maryland Montgo	mery		Bethese						1 Yes 2X No
	is filed within 72 hours after death with the Manyland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 7228 Swansong W	av		10f.	Zip Code 208	17		10g. Citi	izen of What Cou <b>France</b>	·
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99	after d I", or i xamin		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	If Yes, Give	No		2X No	, Mexican, Puerto Specify:	Hican, etc.)		Black, White, Specify: אולם	
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ore	ye 1 ar t of Hk if iten or oth		20a. Method of Disposition  1 Description 3	Removal from State	Ce	lace of Disposition (Nemetery, crematory of	r other place		Date		ocation - City or T	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Special Special Speci	**	Fina	1 Journey					dbine, N	
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			23a. Part Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death							Approximate Interval Between
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	Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequ	ence of):						
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Box 6876	th cert tendir or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 🗀 Fetal	I death 3 🔲 Ectop	ic pregnancy				23d. Date of deliv	•
. B	requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 ∐ Pregnant at 9 ☐ Unknown	time of d	eath 5 ☐ Other	(specify)				Month	Day Year
P.O.	that the ned by e deta	by Pł	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the underlyin	g cause give	en in Part I.	23e. Did tol	bacco u	se contribute to t	the cause of death?
ds,	equires sen sig ould b								1 🗆 Y	es 2	X No 3 □ Pro	bably 4 🗌 Unknown
<u>0</u>	law re has be le 2 sh	Completed							24a. Was a autops perfor	зу	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
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VIta	ysicia s certi directo	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆	ER/Outpatient 3 🗆	Other	: _	ome 5 (Reside	ence 6	Other (Specif	id.
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Division of Vital Records,	al or A		4  Homicide determine	d building, etc		me, farm, street, fact	огу, опісе		28f. Location (St City or Towr	reet and , State)	d Number or Rura	il Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	edical	29a. Certifier 1 X Certifying Ph	nysician: To the best of r	ny knowle	edge, death occured	at the time, o	date and place, a	nd due to the cause the time, date an	se(s) and	d manner as stat	ed. ause(s) and manner stated.
	the P thin 24 the F mplet	Me	only one) 3 Certifying Nu 29b. Signature and title on certifier	irse Practioner: To the b	oest of my	knowledge, death oc	curred at the	time, date and pla	ce, and due to the	cause(s	) and manner as s	tated.
	F≥₽ö		Linn	folm	-		MD32				e signed (Month, June 9,	
	1		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, Print)						
			Ari D. Fishman,	M.D. 2141			Suite	707 Wa	shingtor	, D	C 20037	
	Stat Registra	e	31. Date filed (Month, Day, Year) 9	2010 32. Fegistra	rs Signati احجی	D. bark	1					

			For State	State of M	aryland /	Department of H  Certificate of L					19590
			Registrar  1. Decedent's Name (First, Middle,	Last)		Octimodic of L		2. Date of De	Reg. No.		3. Time of Death
	Physici		Margery Fitzo	rerald Sc	hnappa	uf		Month	Day		1007 AM
-	/Medic Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death			County of Deat	h
-				General	Hospit		oridge			Darche	
	Funeral Director		227-42-2588	. Sex 7. Ao 1 □ M 2 XXF	ge (In yrs. last i	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 4 / 19 /	1, Year) 1, 934	9. Birt Co	hplace (State or Foreign untry) VA
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
	Maryl -f sho	to	MD Tal	bot		Easto	on				1 <b>∏</b> Yes 2□No
	h the	irec	10e. Street and Number			10f. Zip Code		- I	10g. Citi	izen of What Co	untry?
	th wit	al	29115 Superio	or Circle			21601			USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Example, and the content once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ※ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	•	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0	72 ho 'natur	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16	6a. Decedent's Usual Occupa (Give kind of work done of	during most of work	king	16b. Ki	nd of Business/	Industry
2121	within ene. than '	ldmc	Elementary/Secondary (0-12)	College (1-4or	5+)	Waitress	)			Hotel	
<b>d</b> 2	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, La	st)		, ar dr dr	18. Mother's Nam	e (First, Middle	, Maiden		
an	Aental Aental rked o	To B	Sidney King Y	erby			Eliza	Eliza	bet	h Ward	
Maryland	and Nis mail		19a. Informant's Name/Relationship	(Type. Print)	1:	9b. Mailing Address (Street a	and Number or Ru	ral Route Numb	er, City o	or Town, State, 2	Zip Code)
	and 2 lealth m 27 i		Richard Schnap	pauf/Spou		9115 Superi	<del></del>				<u> </u>
Baltimore,	. Pages 1 trnent of H tant: If iter jury or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			of Disposition (Name of tery, crematory or other place Lincoln Cer	m. 6/7	/10		ntwood	
Ball	permit Depar Impor any In		21. Signature of Funeral Service Lie	rensee		22. Name and Addres	111	-		od F.H. 20754	.,P.A.
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	emplications that caused by one cause on each li	d the death. D					54.56.56.446.55	Approximate Interval Between
ě	Physician		Immediate Cause (Final disease or condition	_a. 5		inus syndr					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):					
		e	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequenc	e of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linet funderlying Cause (Disease or injury that initiated events resulting in death) Last			,					
o,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequenc	e of):		··			
68760,	ate be hysicia he bu	edical		d				w			
39 >	ertifica ing pl	Med	IF FEMALE:								
P.O. Box	Physician: The law requires that the death certificate that been signed by the attending ral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		/			23d. Date of del Month	ivery Day Year
ω, σ	s that gned b	by Pi	Part II. Other significant conditions	1	out not resulting	in the underlying cause give	en in Part I.	23e. Did 1	tobacco u	use contribute to	the cause of death?
ğ	w require s been sig should b	ed k	(eff th	alamic hen	norrhy	Q		1 🗆	Yes 2[	□ No 3□ Pi	obably 4 Unknown
of Vital Records,	law ra as be	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of
E	slcian: The law certificate has b irector, page 2 sl	Con						perfo 1 □ Yes	ormed? 2 di No	death? 1 ☐ Yes	2 □No
Vita	ilcian: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Outration and post Other	26. Place of Dea				
of	Phys rthis ral dir	T	1 Yes 2 No 27. Manner of Death	1 Inpati		Outpatient 3 DOA	4 ⊔ Nursing H	ome 5 Resi 28d. Describe		6 ☐ Other (Spe	cify)
on	nding Ph ith. : After th e funeral	atior	1 Anatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ıy, Year)	Injury Work	? Yes 2 □ No		nor nga	, , , , , , , , , , , , , , , , , , , ,	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 Suicide 6 Could not determine	28e. Place of In	ury - At home, c. <i>(Specify)</i>	farm, street, factory, office		28f. Location ( City or To	Street an wn, State	nd Number or Ru	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	lge, death occurred at the tin and/or investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s , date and	) and manner a d place, and due	s stated. a to the cause(s)
	To the complete of the complet	M	29b. Signature and title of certifier  Ahmed La	bib MD		29c. License	SS 28		29d. Dat	te signed (Mont	h, Day, Year)
de	W 10		30. Name and address of person when the same and address of person and address of person and address of person address of person and address of person addre				MD	2(613	>		
~,,,	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	a Signature	, , , , ,		-(013			
	Registr	ar	JUN	-7 2010 × C	lenur	A. Sake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f-12eror Many Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $A^{M}$ June 2010 8:30 Faran Eugene Stoetzel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Calvert County Hospice House Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 30, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Wisconsin 83 399-22-2071 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ite Medical Examiner must be notified at Florida Maryland Marion 1 ☐ Yes 2XXNo Director Summerfield Saint Leonard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number should be filed within 72 hours after death with 8570 SE 133rd Street 34491 United States 20685 1622 Bayber Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 TYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No altimore, Maryland 21215-0036 1 □Yes 2√√ No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) U.S. Government Econimist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Irene Anderson Frank Louis Stoetzel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s transition of Health ar tant: If item 27 is jury or other transitions. 1622 Bayberry Road St. Leonard, Maryland 20685 Manya Stoetzel / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/11/2010 Cheltenham, Maryland MD. Vet. Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road Port Republic, Maryland 20676 Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 6 Days Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burjal-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Bladder Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Diabetes or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Hospice House 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b-Signature and title June 7, 2010 30. Name and address operson who completed cause of death (Item 23a) (Type, Print) Len 238 Mervinac

DHMH 17 Rev 1/2001

State

Registrar

Saymon

31. Date flied (Month, Day,

32. Registrars Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month June Year 2010 Joan Susan Snyder 4:50 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Mar. 22,1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Funeral New York 1 M 2 X F Director 76 .1934 056-28-9752 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f Gaithersburg MD Montgomery 1 🗌 Yes 2 💢 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral death with 20878 217 Booth Street Apt 221A United States Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dermit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Luscomb Histed Lillian Lydia Stockton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne S. Koster / Daughter 16613 Bethayres Road, Derwood, MD 20855 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State June 6, Alexandria, injury ( 4 ☐ Donation 5 ☐ Other (Specify) 2010 Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner obabl Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy for Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy certificate 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Npatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medica 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) မ 2010 10 4 D35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Myung H. Nam, M.D.,

31. Date filed (Month, Day, Year) **JUN 0 8 2010** 

DHMH 17 Rev 7/2009

Registrar's Signature

400 West 7th Street, Frederick, MD 21701

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Bruce Peter Saupol June 3. 8:56 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours Min. May 18. 1942 101-32-3142 68 NewYork **Director** Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11913 Stonewood Lane 20852 **United States** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Arthur Saupol Mildred Mandel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Michael Saypol, son Persimmon Court, East Brunswick, NJ 08816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗴 Burial 2 🗆 Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rat Cemetery 6/7/2010 Farmingdale, New York 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Ararat Cemetery Mt. 21. Signature of uneral Septice Licensee ANIK 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician PNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA 2-3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Directo (or selectione of) the attending physician and hed for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last MULTIPLE SCLEROSIS YEARS Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 🗌 Yes 2 XNo 1 K Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

BRUCE

Hospital or Attending after death. Director; Aft To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by ti

Registrar

Medical

(Check only one) 29b. Signature and title of certiff

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy P. Lawless, M.D., 8600 Old Georgetown Rd, Bethesda, MD 81. Date filed (Month, Day, Year) JUN 08 2010 Registrar's Signature

(Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

JUNE 3, 2010

29c. License number

D0051268

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5<sup>Day</sup> Physician/ 2010 Jun<u>e</u> 4:55 A.M Thomas Schroeder Α. Medical 4a. Facility Name (if not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year 1939 1 🕱 M 2 🗆 F Months Days Hours Feb. 24, Minnesota Director 577-52-3207 Usual Residence of Deceden show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 9502 Quarry Bridge Court <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1957 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 1959 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Magdeline Ann Floyd Charles Schroeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Schroeder/Daughter North Warfield Drive, Mount Airy, MD. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/9/2010 Silver Spring, MD. Gate of Heaven Cem. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset a Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine executed Cause (Disease or linjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Yes 2 No. g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital Other: <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending s after death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

Registrar

only one

29b. Signature and title of certifier

Year)

JUN 09

31. Date filed (Month, Day,

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

2010

Registrar's Signatu

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ **EDWARD** NATHANIEL SCOTT June 2010 10:29 p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number **Funeral** Hours 1 🛣 M 2 🗆 F June 6, Virginia 1936 Director 224-40-5207 73 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No NC Pamlico Bayboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 28515 U.S.A. 4546 North Carolina Highway 12. Was Decedent Ever in Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No 1956 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 to 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Black Completed 1962 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty Nursing Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Herbert T. Scott Justine Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 9102 Constantine Drive, Ft. Washington, MD 20744 Ruby Ford-Baker, Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/14/2010 Triangle, VA Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 2 020 \$ 22. Name and Address of Facility AMES FUNERAL HOME, INC. Barnaido Amas VA 20110 8914 Quarry Road, Manassas, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Pnysician/ ACUTE MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of Examiner RESPIRATORY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injun 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

7600 CARROLL AVENUE, TAKOMA PACK MARYLAND JODRIE, MD FACEP Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

TERRY

300 PIL

D40324

29d. Date signed (Month, Day, Year)

7, 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

17. Father's Name (First, Middle, Maiden Surrame)   18. Mother's Nam				State Registrar	C	Certificate of D		R	leg. No. 2	9596
St. Sachly Name Or red realization, your warred with methods and provided in the company of the		Physicia	an					Month	Day Year	
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Physician / Medical Examiner / M				23a. Part 1. Enter the disease, or complications that	caused the death. Do not each line.					Approximate Interval Between
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Section   Column	6	execut and al-trar	xan		o (or as a consequence of):					<u> </u>
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F FEMALE:   F FEMALE:   The property of the	89	± 0 6	edic							
The state of the s		h cer endin use		23b. Was decedent pregnant		2 ☐ Ectopic pregnancy				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.    COPD	B	0 0	sicia	1 Yes 2 No 4 Pre	gnant at time of death		*		Month	Day Year
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier one)  29b. Signature and a kines of person who completed cause of death (Item 23a) (Type, Print)  M. Atkins, M.D 201 Hall Highway - Crisfield, MD 21817	<u>o</u>	nding tth. :: Afte	atio	A tatala	nth, Day, Year) Inju					
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M. Atkins, M.D 201 Hall Highway - Crisfield, MD 21817				30. Name and a kine of person who completed ca	use of death (Item 23a) (Tiv				00110 07	
State 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature		0					eld, MD 2	21817		
				31. Date filed (Month, Day, Year) 32.	Registrar's Signature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 Day Physician/ JUNE 2010 12:15A M KATHRYN ANNE THAXTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ROCKVILLE CASEY HOUSE HOSPICE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 04910 9ay 40972 229-35-0729 37 ICELAND Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY BOYDS MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20841 15321 BARNESVILLE ROAD filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) MARKETING marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NON-PROFIT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOYCE ATKINSON EUGENE BISHOP of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15321 BARNESVILLE RD., BOYDS, MD 20841 TIM THAXTON / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place)

STAUFFER CREMATORY 06/07/2010 20a, Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death YYS shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ METASTATIC PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 N 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) D47123 JUNE 6, 2010 Murmana

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

BRECKA

JOSEPH PUTHUMANA, MD 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20855

ankal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 June 2:05 P М Rita Tyler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Aug. 12, 1915 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 □ M 2 😾 F Director 223-82-5812 Yrs 94 Aug. Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 127 S. Harrison Street 21601 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Walton Cudmore Carroll Raymond Jardin Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other tran-Marie R. U'Ren/ Daughter 127 S. Harrison St., Easton, Md. 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) August 3, 2010 Arlington National Arlington, VA 21. Signature of Moneral Service Incenties MO1315 22. Name and Address of Facility DeVol Funeral Home Man A 2222 Wisconsin Ave., NW., Washington DC20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Acute Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to lor as a considuence of Examin sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Uninary tract infection, Sepsis, Anemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Myocardial infarction, Gastrointestinal bleeding, 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? has performed? this certificate Diabetes mellitus, Atrial fibrillation 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **X**Vo 1 X Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1X Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

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DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature at title of certifie

31. Date filed (Month, Day, Year) **JUN 0 9 2010** 

Wise Nute

J.David Guevara-Nieto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

29c. License number

0068405

8600 Old Georgetown Road Bethesda, Maryland 20816

29d. Date signed (Month, Day, Year)

June 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 1, 10:42 P M Janice Elizabeth Will 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Wicomico Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗶 F Director 162-32-5013 72 04-26-1938 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director MD Deal Island Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 9791 Crowell Road 21821 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Year or Dates: White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker none Own Home Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othn any lipiny or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Linton Winifred Billbie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Carl Will/husband 9791 Crowell Road, Deal Island, MD 21821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glenwood Memorial Pk 06/05/2010 Broomall, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Sevi 22. Name and Address of Facility
Hinman Funeral Home #/ M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death my ediate Cause (Final ease or condition resulting in death) **Physician** mucinous /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initial order cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed bunial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9☐ Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy certificate 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient ٩ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after dearh To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of ca 29d. Date signed (Month, Day, Year) 2

87

State Registrar 30. Name and ad ress of person who of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Mt. Vernen Rd, Princes Ame, MD 2853

ath (Item 23a) (Type, Print)

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kenneth Herrington Webster, Sr. 20 10 Medical Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Nicomic 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland 1 X M 2 □ F Hours Min. 05-07-1 217-30-9150 Director 76 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Somerset Deal Island 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9800 Deal Island Road 21821 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ ∐Yes 2 💢 No 72 hours after 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) none Contractor **Building** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Charles Baker Webster Atha Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Windsor Webster/wife 9800 Deal Island Road, Deal Island, MD 21821 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State St. Johns Cemetery 06/04/2010 Deal Island, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Vignature of Funeral Service Licenses Himan Funeral Home M00295 11673 Somerset AVe., Princess Anne, 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Y CO515 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury pue to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 certificate 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 124 hours after death. • Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strybupy us 6 Huran

State

Registrar

31. Date filed (Month, Day, Year)

32. Reg

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JUN 0

strar's Signature

10-04275 Dwayne Marcus	Wil		or Print in B e of Maryland									1960
		1- For State Registrar		Cer	tificate o	f Death			Reg. N	11-02 10-1	U	1000
Physicia Medical Exami		Decedent's Name (First, Middle,L	•					Mont	of Death h Day	у Үеаг	1	Time of Death 0030 hrs
Medical Exami	1161	Dwayne Wi  4a. Facility Name (if not institution, s	11iams	•)	-	4b. City, Town, o	or Location of [		5, 2010	4c. County of		
, , , , , , , , , , , , , , , , , , ,		701 N. Bridge Street	,	,		Elkton				Cecil		
Funeral			Sex 7. Ag	ge (In yrs. le	est birthday)	If Under 1 Ye	$\rightarrow$		te of Birth(M	M/DD/YYYY)	9. Birthpl Foreign	lace (State or
Director		221-62-8878 1	X M 2 F	3	30 Yrs	Months Da	ys Hours	Min. Ma	ay 4.		Countr	DE DE
any		Usual Residence of Decedent  10a. State 10b. County		Inc City	Town or Local	ion					10	Od. Inside City Limits
<b>*</b>	_	DE New C	astle		lming							X Yes 2 No
vith the Maryland \$ 23a or 28a-f show \$ notified at once,	Director	10e. Street and Number		1 111	TIMETIE	10f. Zip Code		_	10g. C	itizen of Wha	t Country	n
the M a or 2 tiffed	Dire	3019 Stoddard	Place			10	802			USA		
ı with ms 23 be no	eral	11. Marital Status	12. Was Deceden			as Decedent of H	lispanic Origin'					n Indian, Black,
r death or ite must	Funeral	1 X Never Married 2 Marrie	1 Yes 2	X No				derto Ricari, e	AC. )			
rs afte	ρ	Widowed 4 Divorc     Decedent's Education (Specify	or Dates:	moleted)	16a Deceder	Yes 2 X N		id of work don	e   165	Specify: ]	Blac	
72 hour "nat	eted	Elementary/Secondary (0-12)	College (1-4 or			ost of working lif				. Kind of Edsi	1000/11/00	2011 9
036 /ithin ' ene. er thau	Completed	12	4		Truc	k Driv	er			Trucki	ing	Company
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, La	*					Name (First, N		•		
2127 Ild be i Mental narke event	To Be	John Stansbury  19a. Informant's Name/Relationship			19h Mailin	g Address (Stre		ry Wi			State 7i	in Code)
MD 2 d 2 shou lith and l		Terry Williams			100					•		19802_
e, N 1 and 1 Health item		20a. Method of Disposition	_	20b. F	Place of Dispos	sition (Name of c	emetery,	Date	200	c. Location - C	ity or Tov	wn, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 X Burial 2 Cremation 3 4 Donation 5 Other Speci		tate Gr	rematory or ot acelay	wn l Park		6/11/	2010	Morr	Coo	tle DE_
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lio		THE	22. N	lame and Addre	ss of Facility	Congo	Fune	eral H	lome	rie, Dr
							x 2593	3.Wilm	ingto	on. DI	<u>. 19</u>	805
Physician		23a. Part I. Enter the disease, or cor failure / st only one cause on	each line.			he mode of dying	g, such as card	diac or respira	tory arrest, s	shock, or heart		Approximate Interval Between Onset and Death
Examiner		Immediata Cause (Final disease or condition resulting in death)	Due to (or es a cons								+	Deatri
		Sequentially list conditions,	b	-	,							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of	):							
-	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	):							
ecuted and transit			d			····		•			_	
O, be ex sician	gi	UNPENDED	AMENDED									
Box 68760 e death certificate b the attending physical ed for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregr		tal death 3	Ectopic pr	regnancy	2	23d. Date of de Month	elivery Day	Year
x 6 th cer ttendi	01	past 12 months?  1 Yes 2 No 9 Unknow		t time of dea	ath T	her (Specify)			0.40		·	
. BC the dear	Physic	Part II. Other significant condition	9 Unknown	th but not re	eulting in the	inderlying cause	civen in Part I	1 23	Did tobaco	o use contribu	ite to the	cause of death?
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be execut certificate has been signed by the attending physician and extor, page 2 should be detached for use as the burial - tra	اھ	Tartil Office Significant condition	contributing to deal	in Dat not re	suiting in the t	indenying cause	giveiriiraiti					ly 4 Unknown
ds, equire een si	Completed	<del></del>						248	a. Was an			sy findings available
Records, The law requir fricate has been s	ď							<b>–</b> [	autopsy performed	? dea	ath?	pletion of cause of
tal Recicion: The certificate		25. Was case referred to medical				26.Plac	ce of Death (Ch		Yes 2	No 1	/ Yes	2 No
of Vital ng Physician: ufter this certi	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2	ER/Outpatient		Othor	lursing Home		dence 6 🗸	Other: So	cene
n of ding Ph	١	27. Manner of Death	28a. Date of Inju Month Day, Jun 5, 2010	ury Year)	28b. Time of I		ury at Work?	Subjec	scribe how i	njury occurred	j	
Sion trendi death. ctor: y the fi	atio	1 Natural 5 Pending 2 Accident Investiga	ntion		0016 hrs		Yes 2 ✔ No	0	onograda			
Division repital or Attendi hours after death.	ertification:	3 Suicide 6 Could no	at be 28e. Place of Ir			et, factory, office	building, etc.	or -	Town, State)			Route Number, City
.g. 9 g.c.	O	29a. Certifier	(0,000.), Fa		_	red at the time	data and slass			eet, Elkton, N		
To the Hos within 24 h To the Fun	edical	(Check only Certifying Friys	cian: To the best of mer:On the basis of exa	-								ause(s)
To To	ě	29h Signature and title of certifier	and manner_stated.			29c Licen	se number		200	1 Date signed	(Month	Day Voos)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Jack Titus MD. Deputy Chief Medical Examiner 1

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

June 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1, Decedent's Name (First, Middle, Last) Year 20/0 LINWOOD WILLE 06 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death ANNAPOLIS ANNE ALUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)
April 2, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Days Hours Months 1 M 2 □ F 63 1947 Maryland 219-46-2652 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 XYes 2 No Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 103 Teal Lane 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) welder automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linwood E. Willey Blanche English 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife 103 Teal Lane, Cambridge, MD Mary C. Willey 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/10 Dorchester Mem. Park Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTHS HEPATIC CIRRHOSIS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HEPATIC ENCEPHALOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

items 23a or 28a-f show

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"natural"

d 2 should be filed within 73 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

72 hours after

Baltimore, Maryland 21215-0036

/Medical

MD

physician and the burial-transit attending phase as the ed by the a cate has been signed page 2 should be det certificate has director, After this funeral

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Examine

Physician/Medical þ Completed Be

Certification: To

Medical

To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

5 Pending

29b. Signature and title of cer

and manner stated. 29c. License number

2 ER/Outpatient 3 DOA

28b. Time of

6675

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Annavolis

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medica 2001

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day, Year)

1 moth MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / Department of Health an Certificate of Death						0010 10000			
			Registrar  1. Decedent's Name (First, Middle, Las							2. Date of Dea	Reg. No.		3. Time of Death
	Physicia			arfield						Month	8, <sup>Day</sup>	Year	11:50A M
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, 1	own, or Loca	ation of Death	Dune_		unty of Death	11.50A
			Brooke Grove Reha	b & Nursin	g Cen	ter	Sa	ndy Sp	oring			Montg	omery
	Funeral		5. Social Security Number 6. S	12 Malle	(In yrs. last		If Under Months		Inder 24 Hrs.	8. Date of Birt	h v. Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		90	Yrs.				NOV 4	1919	West	Virginia
5	show	or	10a. State 10b. County		10c. City, 1	Town or Loc	ation			-			10d. Inside City Limits
Mond	28a-f	rect	Maryland Montgom	ery		Si	lver	Spring	3				1 🗆 Yes 2🔀 No
4	a or 2	Ö	10e. Street and Number				10f. Zip	Code			10g. Citizer	of What Cou	ntry?
And the state of t	ns 23	Funeral Director	15101 Interlache					0906			Uni	ted St	ates
			11. Marital Status  1  Never Married 2  Married	12. Was Decedent Ev Armed Forces?		13. W	Vas Decede Yes, speci	ent of Hispani fy Cuban, Me	iic Origin? (Spe exican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
05.00-61212	al", o Exam	d by	3 Widowed 4 Divorced	1 □XYes 2 □ N If Yes, Give Year or Dates. <b>1</b> (		_ 1	☐ Yes 2	ĭNo Sp	pecify:		Spe	ecify:	White
5	natur lical I	Completed	15. Decedent's E	ducation		16a. Deced		Occupation			16b. Kind	of Business In	
<b>7</b> 2	e. han " • Mec	dwo	(Specify only highest gra Elementary/Seconday (0-12)	college (1-4 or 5+	-)	(Give k life. DC	nd of work NOT use	: done during retired)	g most of worki	ng			
	Hygiene.	Be C	12			Ins	uranc	<u>e Agen</u>					Insurance
and	ed of	To B	17. Father's Name (First, Middle, Last)	** 6' 33						e (First, Middle,		name)	
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<b>Z</b>	1 ± 22 ±		Lillian W. Warfie		- 1					il Route Numbei			g, MD 20906
ā, j	of Health item 27 other tra		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name	e of		Date		ion - City or T	
OE S	int: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif			netery, crem	-		ory 6/	10/2010	Wood	lhine.	Maryland
Baitimor	Department of Inportant: If ite any injury or of once.		21. Signature of Funeral Service Licens		12 222	_						-	
ם פ	88 = 88		Juanita KY	homas	M009	57 B	everl	y L. H	ieckroti	te, P.A	Clar	ksvill	784 e, MD 21029
			23a. Part Enter the disease, or comp shock, or heart failure. List only o	olications that caused to ne cause on each line.	the death. I	Do not ente	r the mode	of dying, suc	ch as cardiac c	r respiratory arr	est,		Approximate Interval Between
P	ıysicia		Immediate Cause (Final disease or condition	. Pneumo	onia								Onset and Death  1 week
	Medical xaminer		resulting in death)	Due to (or as a		nce of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Sepsis		ace off:							1 week
þe	nsit	mi	cause. Enter Underlying Cause (Disease or Impury	SUBSECTION OF THE PARTY OF THE			ictan	t Stan	htrl occ	ccus Au	COLLE		1 week
Xecu	in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a			<u> 15 carr</u>	c ocap	лутосо	cus nu	Leus		1 week
oc ate be	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner		d									
OO/C	ng ph as th		IF FEMALE:									-	
Th cer	ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	P 🔲 Fetal d	leath 3 🗌					230	. Date of deliv Month	ery Day Year
DOX e death c	the all	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of dea	ath 5∟	Other (spe	ecify)				MONTH	Day fear
; ŧ	ed by detac	h h	Part II. Other significant conditions of	ontributing to death but	t not result	ing in the ur	nderlying a	ause given in	Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
U, I	sign Id be	d by	Dementia							1 🗆 🕆	Yes 2 🔀	No 3 🗆 Pro	bably 4 🗆 Unknown
e law requires	shou	lete								24a. Was a	an 2	4b. Were auto	psy findings available
he la	te has age 2	Completed					_				rmed?	prior to co death? 1 \(\sum \) Yes	impletion of cause of
an:	rtifical tor, p		25. Was case referred to medical					26. Place of	of Death (Check	1 L Yes	2 ( <b>X</b> No	T L Tes_	2 🗆 NO
VILCII	nis ce I direc	2	1 L Yes 2 XI NO	Hospital: 1 🗌 Inpatier	nt 2 🗆 EF	R/Outpatien	t 3 🗆 DO.	Other: 4	X Nursing Ho	me 5 Resid	lence 6 🗆	Other (Specify	)
5 6	fter th		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day,		8b. Time of injury	28	c. Injury at work?		28d. Describe h	ow injury oc	curred	
VISION or Attendir	tor: A the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not b				М	1 🗆 Yes					
S P P	after of Direction by	Certificate:	4 Homicide determined	28e. Place of Injury building, etc.		e, farm, stre	et, factory,	office		28f. Location (S City or Tow		umber or Rura	l Route Number,
spital C	nours neral filled	cal	29a. Certifier 1 X Certifying Phys	sician: To the best of m	ny knowled	lge, death o	ccured at t	ne time, date	and place, an	d due to the car	use(s) and m	anner as state	ed.
e Ho	n 24 h	Medical	(Check 2 L Medical Exami	ner: On the basis of exa se Practioner: To the ba	amination a	nd/or investi	igation, in m	y opinion, de	eath occurred at	the time, date a	nd place, an	d due to the ca	use(s) and manner stated.
Toth	To th		29b. Signature and title of certifier	,				License num				gned (Month,	
			MIM	ille MI	0		_   I	00506	12		June	8, 20	10
6	H		30. Name and address of person who o										
_			Samuel G. Maller	M.D. 3305	N. I	Leisur	e Wor	ld Bl	vd. Sil	ver Spr	ing,	MD 2090	06
	Stat Registra	е	31. Date filed (Month, Day, Year) 9 2	010 SZ. Megistrar	s signature	1 6	asked	•					

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Iviar		tificate of		ia ivientai my	Reg. No.		19604
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
James	Medic	al	Mary Collins Weat  4a. Facility Name (if not institution, give st			4b. City, Town,	or Location of F		04, 201 4c. County		6:00 A M
	Examin	er	Shady Grove Adven		tal	Rocky		Jean		gomer	*v
	Funeral		5. Social Security Number 6. Sex	7. Age (/	In yrs, last birthday)	If Under 1 Year Months Days	If Under 24		th		place (State or Foreign
	Director		036-18-8541 Usual Residence of Decedent	M 2 XF	85 Yrs.	Wierians Baye	Tiodio	Min. (Month, Da May 18	1925	Rho	de Island
	and show lat	or	10a. State 10b. County	1	Oc. City, Town or Loc	ation				1	10d. Inside City Limits
	the Maryland or 28a-f show e notified at	Director	Maryland Montgome	ry	Gaither	sburg	_		_		1 🗶 Yes 2 🗌 No
	th the	alD	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath wi	Funeral	401 Russell Avenue	#412 2. Was Decedent Eve	arin IIS 13 V		877 Hispanic Origin	2 (Specify Yes or No-	United	Sta	
ဖွ	ter de	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗓 No				? (Specify Yes or No- uerto Rican, etc.)	Bla	ck, White,	
Maryland 21215-0036	rurs af tural" al Exa	Completed	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates.		Yes 2 X N			Specify	wn:	ite
-51	72 hc in "na Medic	mple	15. Decedent's Edu (Specify only highest grade	e completed)	(Give I	lent's Usual Occu iind of work done D NOT use retired	during most of	f working	16b. Kind of B	lusiness In	dustry
212	within giene.	Col	Elementary/Seconday (0-12)	College (1-4 or 5+) 4		ition Sp	,	t	Federa	al Go	vernment
pu	tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle,		e)	
Z Za	uld be d Men narke natic		Patrick J. Collin		4			herine For			
Ma	2 sho	. 1	19a. Informant's Name/Relationship (Type Barbara W. Bosco			•		or Rural Route Numbe Place Geri			^9874
Je,	1 and of Hea of Item r other		20a. Method of Disposition		20b. Place of Dispo-			une 12	20c. Location		
imo	Page ment c tant; If		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metropoli	Ltan Cre	matory	2010			, Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once.		nature of Funeral Service Licenses	Alul	. X .			DeVol Func k Drive Ga			MD. 20877
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the cause on each line.						Ĩ	Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_Gallston	ne Pancrea	titis					Onset and Death
	Examiner		Toolaing in dodain	Due to (or as a c	onsequence of):						
		iner	Sequentially list conditions, by larry, leading to immediate cause. Enter Underlying	Due to (or as a c	or sequence of/				-		
	ecuted and transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	. — Due to (or as a c	ansequence off:					-	
0	cate be executed physician and s the burial-transit	calE	resulting in death) cast	200 10 (0) 03 0	onsequence en.						ĺ
3760	1 D 2	Medi	- 0	•							
Box 68	aath certific attending p for use as	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of 1 Live Birth 2	Fetal death 3	Ectopic pregnar	псу			ate of delive	
Bo	Attending Physician: The law requires that the death certify a death, are death, are death, ester, After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by Physician/Medical	1 Yes 2 XNo	4 ☐ Pregnant at til 9 ☐ Unknown	me of death 5	Other (specify)			Mo	onth	Day Year
P.O.	requires that the de been signed by the should be detached	y Pr	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause g	jiven in Part I.	23e. Did to	obacco use cont	tribute to th	he cause of death?
ds,	quires en sign	ted b						1 🗆	Yes 2 No	3 🗆 Prol	bably 4 X Unknown
cor	e law rec has be ge 2 sho	Completed						24a. Was autor	osy	prior to co	psy findings available impletion of cause of
Re	Physician: The lav r this certificate has aral director, page 2	Co	25.14					1 Yes	rmed? 2 🛛 No	death? 1 Yes	2 No
/ital	sician certif	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No	ospital:	2 ☐ ER/Outpatien	lot	her:	(Check only one)	с П оль	(0)6	a
of \	ig Phy ter this neral d	te: T	27. Manner of Death	28a. Date of injury (Month, Day, Y	28b. Time of	28c. Inju	ıry at		ow injury occurr		2
ion	tendin leath. tor: Aff the fur	Certificate:	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1	Yes 2 No				
Division of Vital Records,	al or Attending Physis after death. I Director: After this din by the funeral di		4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	et, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	er or Rural	l Route Number,
	To the Hospital or A within 24 hours after y To the Funeral Direct completed filled in by	Medical	29a, Certifier 1 XCertifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of exar	mination and/or invest	igation, in my opir	ion, death occur	rred at the time, date a	nd place, and du	ie to the cai	use(s) and manner stated.
	To the within To the Complex		29b. Signature and title of ontifier	Practioner. To the bea	st of my knowledge, c	29c. Licen:			29d. Date signe		
	20		· M	John 2		D20	148		June 0	7, 20	010
			30. Name and address of person who cor				h one - 1	- MD 200	77		
	Stat	e	Steven Dolinsky M.  31. Date filed (Month, Day, Year)	D. 911 Rus			nersbur	g, MD. 208	0//		
	Registra		JUN 08 2010	2	Signature	1					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 06/05/2010 Joseph Andrew Weaver 1:50 PM /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospice of the Chesapeake-Tate House Linthicum Anne <u>Arundel</u> If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Security Number 8. Date of Birth (Month, Day, Year) Months 1**X** M 2□ F Days Director 79 03/25/1931 240-42-6251 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm M. dical Evaring any injury and other traumatic event, I'm M. dical Evaring and injury or other traumatic event. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 224 Homewood Road USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ∑Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: Korean 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Systems Engineer IBM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 <u> Alice Small</u> <u>Joseph Andrew Weaver</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Kiefe/Wife 224 Homewood Road, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 06/07/10 Alexandria, VA 22. Name and Address of Facility Advent Funeral Services 21. Signature of Funeral Service Licen 06 42 Hudson Street, #110, Annapolis, MD 21401 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the di shock, or he rt fail Immediate Cause (Final disease or condition resulting in death) **Physician** Oyeur /Medical Due to (or as a consequence of) **Examiner** Terior Societically list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed □Yes 2 No 25. Was case referred o medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 StOther (Specify) np w 12 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation filled in by the fi 1 ☐ Yes 2 ☐ No death 2 Accident Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and thre a certifie 29c. License number MM 30. Name and ad pss of person who completed cause of death (item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

09

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

MI

32. Registrar's Signature

min men

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 960 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 4. Weinstein 2010 Dorothy 1:50 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14305 Northwyn Drive Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min. 04/30/1926 Ohio Director 279-20-4843 84 Usual Residence of Decedent fshow 10a, State 10b. County 10c. City, Town or Location n "natural", or items 23a or 28a-f sho edical Examiner must be notifled at 10d. Inside City Limits Director MD Silver Spring 1 X Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b. Completed by Funeral USA 20904 14305 Northwyn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 😾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Non-Profit Volunteer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Solomon Goldstein a.k.a. Sam Goldstein Gussie Spayser a.k.a. Grace Spayser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Beacon Street #31, Somerville, MA Joseph Weinstein, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗓 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) King Solomon Mem Pk 06/07/2010 Clifton, New Jersey 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 Rockville Pike, Rockville, Signa e of Europe Service Licenses MO1255 Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastic Lung Cancer disease or condition resulting in death) vears Medical Due to (or as a consequence of) Examiner Primary Lung Cancer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 1 Yes 2 No Yes 2 tz No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 😾 Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral the Hospital 5

29a. Certifier

(Check

29b. Signature at

Dr. Mahrukh Hussain, 1396 Piccard Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0060050

29d. Date signed (Month, Day, Year)

June 4, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2010 Witkin Leonard E. 2225 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year 05/11/192 9. Birthplace (State or Foreign Country) Virginia 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. Funeral Days 1**X** M 2 □ F Months Hours Min. 89 Yrs **Director** 579-18-2619 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 701 Lowander Lane 20901 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No 1941 –
If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Specify Completed White. 1945 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 | and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Liquor Store 12 Owner traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Witkin Lena Seagal Department of Health and Important: If item 27 is n any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann N. Witkin - Spouse 701 Lowander Lane, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lebanon Cemeteru: 06/10/2010 Adelphi, Maryland 22. Name and Address of Facility Hines-Rinildi Funeral Home, Inc. Signature of Futieral Service London 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Septic Shock Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause (Disease or linjury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the control of the second to Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Myelocytic Leukemia 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Gastrointestinal Bleeding 24a. Was an page 2 autopsy performed? Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? (0) 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at vithin 24 hours after death.

To the Funeral Director: After is completed filled in by the funeral 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 D69288 June 08, 2010 war. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 1500 Forest Glen Road, Silver Spring, MD 20910

MD,

32. Registrar's Signature

Yodit Woldemichael Negusse,

31. Date filed (Month, Day, Year) JUN 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 30<sup>Day</sup> 2010 7:05PM Seymour Horace Wollman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country)
New York Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🛂 M 2 🗆 F Hours May 17, Year 1915 **Director** 216-44-9623 95 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 ₹ Yes 2 □ No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? õ event, the Medical Examiner must be Funeral 23a 9628 Old Spring Road 20895 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc ò þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Scientist NTH Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Abraham Wollman Miriam Deborah Tencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Arnold Wollman, Son</u> 9628 Old Spring Rd, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/10/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Simple Tribute M0146322. Name and Address of Facility Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition Physician/ 5 days Pneumonia 4 6 1 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 687 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) 9 Unknown the hed 9 Unknown signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure 2X No 3 ☐ Probably 4 ☐ Unknown CHF 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No this certificate Diabetic Ketoacidosis Yes 2 X No Vital 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 😾 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending □ Accident
□ Suic NOLLMAN thin 24 hours after death. the Funeral Director: Af mpleted filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F complet 3 🗆 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20 D0060117 6/1/10 MD 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric D. Park, MD Suburban Hospital 8600 Old Georgtown Rd. Bethesda, MD 20851 31. Date filed (Month, Day, Year) JUN 0 9 2010 32. Registrar's Signature State

Registrar

1905

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SEYMOUR

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	_	For		State of M	1arylan					lental Hyg	jiene		
		State Registrar				Cer	tificate	of Death	7	F	Reg. No.	010	9609
Physicia Medic		1. Decedent's Name (Firs	t, Middle, Lasi		W	RIG	HT			2. Date of Dear Month JUNE	Day	2010	3. Time of Death
Examine		4a. Facility Name (if not in	stitution, give	street and number)				wn, or Locatio	on of Death		4c. Cou	inty of Death	
		SOUTHER	N MARY	LAND HOSP	ITAL		CLINI	ON			PRI	NCE GE	EORGE'S
Funeral Director		5. Social Security Numbe 226-20-856	4 12	X X M 2 □ F 8		ast birthday) Yrs.	If Under 1 Months I	Year If Und Days Hours	der 24 Hrs. s Min.	8. Date of Birth (Month, Day JUNE 20	) 1925	Cour	place (State or Foreign htry) SINIA
d d		Usual Residence of Dece 10a. State 10b.	dent County		10c City	, Town or Loc	eation						10d. Inside City Limits
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s after de al", or it Examine	þ	1 Never Married 2		Armed Forces'  1 X Yes 2  If Yes, Give Year or Dates.		VY	Yes, specify	Cuban, Mexic		Rican, etc.)	Spec	Black, White, cify: <b>BI</b>	etc. LACK
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be fi lental rked ic ev	မ	ALLEN JA	MES					l F	ELLEN	WRIGHT			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/F			INLA	19b. Mailin	ng Address (S	Street and Nun	nber or Rura	Route Number,	City or Tow	n, State, Zip	Code) 20744 MARYLAND
e 1 and t of Heal If item 5		20a. Method of Disposition	on	· · · · · · · · · · · · · · · · · · ·	20b. P	lace of Disposemetery, crem	sition (Name	of	1	Date	20c. Locati	on - City or T	own, State
t. Pag tmen tant: ijury		4 Donation 5 □	other (Specify	2	)HA	RMONY			6/8/				ARYLAND
permir Depar Impor any in		21. Signature of Funeral	Service Licens	ee				Address of Fa	-	LANDOV			20785
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, Medical Examiner		disease or condition resulting in death)	C	Due to (or as	s a consequ	ience of):	- Y~8	- I	~/~				
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be executed sician and burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  ASPINATION PNEUMONIA  Due to (or as a consequence of):  ONSETTIVE HEART FAILURE  Due to (or as a consequence of):  CHARRIA VASCULAE ACCIDENT -  Due to (or as a consequence of):  CENSINAL VASCULAE ACCIDENT -  Due to (or as a consequence of):											
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To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	hs?	1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of c	l death 3 L	Ectopic pre Other (spec				230.	, Date of deliv Month	Day Year
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Attender deathector: /	Certificate:	2 Accident 3 Suicide 6 C 4 Homicide	Investigation Could not be determined	28e. Place of Ir	njury - At ho		M eet, factory, o	1 Yes 2		28f. Location (S City or Tow		ımber or Rura	al Route Number,
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or wit		29b. Signature and title of	of certifier	(V)			29c. L	icense numbe	er	_	_	gned (Month,	Day, Year)
		30. Name and address of	person who o	ompleted cause of	death (Item	23a) (Type, F	Print)	1206	5329		JUNE	03	<u> </u>
2 5 Stat	0	RASHEED  31. Date filed (Month Da	ABASS		750 træs Signa		CRATT.	s Roa	D. (1	INTON	/ N	10 2	10735
Stat Registra		JUN 0 9 7	2010 /	Energy 1	B. A	dre Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JUNE 20 To 5:57 a M PEGGY WRIGHT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 M 2 X F Days Hours Min. Apr 10, Country) 1942 Director NC 237-66-8287 68 Usual Residence of Decedent filed within 72 hours after death with the Maryland ms 23a or 28a-f shomust be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 7911 Denmeade Ave. USA ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than 'arry or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Assistant Metro 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Henry Thompson Lena Breeze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Wright - Husband 7911 Denmeade Ave. Ft. Washington, MD. 20744 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or 4 Donation 5 Other (Specify) Payne Chapel Cemetery 6-12-2010 Hillsborough, NC. 21. Signature Funeral Service Licenses Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Dav Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2. No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? this certificate 2 No 1 🗌 Yes Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours at To the Funeral D Medical 1.X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00 68080 06 | 05 | 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rickville, Md. 20850 Sireesha Jalli, MD 9901 Medical Center Dr.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 **9 2010** 

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ June 8, Year 2010 Ploutarchos Xenophon tos 5:00 a М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehab. Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign April 9 Day 1919 Cyprus 1 K M 2 🗆 F 140-24-8885 91 Director Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Mon toomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 706 Stirling Road 20901 TISA death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify "natural", 3 Divorced Completed Year or Dates. WWII Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chef Hotel Restaurant Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Xenophon H. Xenophontos Anastasia Unknown other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Stirling Road, Silver Spring, MD 20901 Sophia P. Xenophontos/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of June 10 20c. Location - City or Town, State cemetery, crematory or other place)

Gate of Heaven Cemetery 1 K Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Li 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or co shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ detached for in the past 12 months? Day Year Pregnant at time of death 2 No g 🗌 Unknown g 🔲 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 1 Yes 2 No pade certificate 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 의 1 Yes 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury s after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) beleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 8, 2010 D09834

State

Registrar

3720 Farragut Avenue, Kensington, MD 20895

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rosenbaum, MD

O NUL

31. Date filed (Month, Day, Year)

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	ind show at	ō	Usual Residence of I 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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21215-0036	e fied within 72 hours after death with the Maryland field within 72 hours after Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1X Never Marrie 3 Widowed 4		Armed Forces? 1   Yes 2   If Yes, Give Year or Dates.		- 1			n, Mexican, Puerto Specify:	o Rican, etc.)		Black, White Specify: Bla	
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pu	tal Hyg ed oth event,	To Be	17. Father's Name (F	irst, Middle, Last)						18. Mother's Nar	•		Surname)	
Maryland	1 and 2 should be file if Health and Mental I item 27 is marked o other traumatic eve		Robert  19a. Informant's Nai	Lee		toke		na Addra	e (Street	LOIS and Number or Ru		Wis er City o	or Town State Zin	n Code)
	and 2 sho Health an tem 27 is ther trau				n(Fiance	<u>.</u> )								o., MD21215
ore,	~ 0 4		20a. Method of Disp		Removal from State	20b. P	Car his	sition (Na Cternor	ame of other plac	:e)	Date	l	Location - City or	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o			5 Other (Specify	) .	Car	riso	a Fe	rest	<del>-</del> 106/.			ltimore	·
Ba	Depa Impo any i		21. Signature of Furi	re huce	LN.U	Illes	mo 2	1 4 0	N. I	Fulton I	Ave.,B	alt.	imore,M	ome P.A. ID 21217
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):								Approximate Interval Between Onset and Death						
	Examiner	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under	mediate lying	b. Due to (or as	a consequ	uence of):					_		
	ath certificate be executed attending physician and for use as the burial-transit		Cause (Disease or in that initiated events resulting in death) L		c. Due to (or as	a consequ	uence of):				_			
Box 68760	ertificate ding phy se as the	/Medi	IF FEMALE:		23c. If yes, outcome	of pregna	ncv						23d. Date of de	liver
. Box	that the death or led by the atten detached for us	Physician/Medical	23b. Was decedent   in the past 12 n 1 Yes 2 G 9 Unknown	nonths?	1 Live Birth 4 Pregnant a 9 Unknown			Ctopic Other	pregnand specify)	Sy			Month	Day Year
ls, P.O.	v requires that to been signed be should be deta	by	Part II. Other signifi	icant conditions co	s contributing to death but not resulting in the underlying cause given in Part I.					ven in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
of Vital Records,	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.  Librarel Director: After this certificate has been signed by the attending physici tred filled in by the funeral director, page 2 should be detached for use as the bu	Completed				-		1	٤		24a. Wa auto per 1 \(\sum \) Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
tall	cian; sertifica ector, p	Be	25. Was case referre examiner?	/ h	Hospital:					ace of Death (Che				
n of Vi	ding Phys h. After this of funeral dir	cate: To	1 ☐ Yes 2 ☑ 27. Manner of Death 1 ☑ Natural 2 ☐ Accident	1 NO	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ The Forsing Input at work?  28b. Time of injury (Month, Day, Year)  28b. Time of injury at work?				Home 5 X Residence 6 Other (Specify)  28d. Describe how injury occurred					
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; At completed filled in by the fu	Certificate:	3 Suicide 4 Homicide	6 Could not be determined		ury - At ho c. (Specify	me, farm, str	eet, facto	ory, office		28f. Location City or To			ral Route Number,
_	Hospita 24 hours Funera leted fille	Medical	(Check 2	☐ Medical Exami	fician: To the best of her: On the basis of e e Practioner: To the	examination	and/or inves	stigation, i	n my opini	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
	To the To the compl	2												
			30. Name and addre	ess of person who a	ompleted cause of completed cause of completed cause of completed cause of complete cause cause of complete cause of cause cau	death (Item	n 23a) (Type, I	Print)	-239	5 - Ball	fimore		y.D. 2	1209.
	Sta Registra		31. Date filed (Month	2010 A	32. Regist	r's Sign	ure del							

10-04550							
Jeffrey Barron							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Jeffrey Barron	State 1- For State Registrar	of Maryland / Depa Cen	rtment of tificate of		Mental Hy		2010 ag. No.	19613
Physician/ Medical Examine	Decedent's Name (First, Middle, Last	rey Scott Baro	on.			2. Date of Deat Month June 15, 2	h Day Year	3. Time of Death 2206 hrs
	4a. Facility Name (if not institution, give 11801 Rockville Pike #402	street and number)		b. City, Town, or Lo Rockville	ocation of Death		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 6. Se 025-36-5769 1 X	7. Age (In yrs. Ia M 2 F 50	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birt	6, 1959 Foreig	
any	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	n .				10d. Inside City Limits
the Maryland a or 28a-f show tified at once.	Maryland Monto	omery	Rockvi			Le 10g. Citizen of What C		1 χ Yes 2 No
Di fifige the	11801 Rockville F	ike, #402 12. Was Decedent Ever in U.S	S. 13. Was	2 Decedent of Hispa	0852	ecify Yes or No-	U.S	can Indian, Black,
ifter death with 11", or items 23 1er must be no y Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year	If Ye	s, specify Cuban, November $2X$ November $2X$	Mexican, Puerto F		White, etc.	White
ore, MD 21215-0036 s: I and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", of her traumatic event, the Medical Examiner To Be Completed by F	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	or Dates: y highest grade completed)  College (1-4 or 5+)		s Usual Occupation st of working life, D			16b. Kind of Business/I	
MD 21215-0036 and 2 should be filed within 72 hour thin and Mental Hygiene. m 27 is marked other than "natur aumaric event, the Medical Exam To Be Completed	17. Father's Name (First, Middle, Last)	2	-	Sales 18.	Mother's Name (	First, Middle, M		tail
D 21215-003 should be filed within and Mental Hygiene. T is marked other the matic event, the Med	Juds 19a. Informant's Name/Relationship (Ty	on R. Baron pe, Print)	19b. Mailing	Address (Street a			Wasserman ber, City or Town, State	, Zip Code)
e, MD 1 and 2 sh Health an item 27 ir	Jason R. Baron -	20h Pl	ace of Dispositi	on (Name of came)	ton	Bethesdo Date	a, Maryland 20c. Location - City or	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner To Be Completed by F	1 Burial 2 X Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Removal from State Ball	Loudon	proplace) Crematori Park Cem	9 06/	18/2010	Baltimore,	Maryland Home, Inc.
Physician	23a. Part I. Enter the disease or compli	Donnell	1180	10 New Ha	mpshire	Ave., S	Silver Spri	ng, MD 2090 Approximate Interval
/Medical Examiner	failure. List only one cause on eac Immediate Cause (Final disease a	h line. Atherosclerotic c ue to (or as a consequence of):	ardiovaso					Between Onset and Death
ner	Sequentially list conditions, b if any, leading to immediate D	ue to (or as a consequence of):						
ted Insit	Course Chief Underlying Course (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):						
to, e be executed ysician and burial - transit	XUNPENDED X	AMENDED 1 per me 23a,27,p	<b>g904</b> (er ME g90	5 <b>-23-10</b> 5 7/9/10 T	r <b>t</b> T/#8per]	FH <b>,</b> g905	,7/20/2010,	WS
box 68760, the death certificate by the attending physiched for use as the burn Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna  1 Live birth  4 Pregnant at time of deat	2 Feta	death 3	Ectopic pregnand	су	23d. Date of delivery  Month D	ay Year
<b>—</b>	Part II. Other significant conditions	9 Unknown			n in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ords, P.( w requires tha s been signed should be det						24a. Was ar		opsy findings available
ital Records, ician: The law requires certificate has been signered or, page 2 should be Be Completed						autopsy perform	ned? death?	ompletion of cause of
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death		R/Outpatient 3	DOA Oth	Death (Check on	Home 5 R	tesidence 6 🗸 Other:	Scene
Division of spiral or Attending Pt nours after death. neral Director: After filled in by the funeral filled in by the funeral Certification: T	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)		1 Yes	2 No		ow injury occurred	
Divi spital or , hours after neral Diri filled in t	3 Suicide 6 Could not be determined 4 Homicide Could not be determined	(Specify)				or Town, Sta		
To the Hospital within 24 hours a To the Unus a To the Euneral I completely filled	(Check only one) 2 Medical Examiner: (	<ul> <li>To the best of my knowledge, on the basis of examination and and manner stated.</li> </ul>	, death occurred l/or investigation	d at the time, date a n, in my opinion, de	and place, and di eath occurred at t	ue to the cause( he time, date ar	(s) and manner as state nd place, and due to the	d. cause(s)
d Z	29b. Signature and title of certifier			29c. License nu O.C.M.E			29d. Date signed <i>(Mon.</i> June 16, 2010	th, Day,Year)
	30. Name and address of person who co Ana Rubio MD. Assistant	· - · · · -	•	eet, Baltimore,	MD 21201			
State Registrar	31. Date filed (Month, Day, Year)  JUN 2 3 201	32. Resistrar's Signature	1 Sac	الما				
DHMH 17 Rev 1/2001 OCMF 2006			ORIGINAL			00	OME	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $21^{\text{Day}}$ JuMPeth Francis John Brown 2010 12:41 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Carrol1 Westminster Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth XX M 2 D F Days 83 **Director** 194-20-0760 0ct PA Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖁 No MD Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1395 Dennings Rd. 21776 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? AMYes 2 No 1944-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 1946 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Printer Gov Printing Office injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Francis J. Brown Helen Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trans Tim Brown (Son) 1395 Dennings Rd. New Windsor, MD 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) ake View Memorial Park 6/25/2010 Sykesville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Currier-Queen Funeral Home and Crematory, P.A. Old Liberty Rd 212 W. Winfield. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between et and Death Immediate Cause (Final Physician, CONORATINE owented disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ 3 in the past 12 months Pregnant at time of death Month Day Year 2 1110 signed by the a d be detached f Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed: Yes 2 N 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1  $\square$  Yes .2 WNo Other: 은 PICE 1 Inpatient 2 ER/Outpatient 3 I this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending s after death. Il Director: Af ed in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide determined City or Town, State, 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and hitle of certific 29d. Date signed (Month, Day, Year) df06 2010 npleted cause of death (Item 23a) Type, Print) 21136

State Registrar 31. Date filed (Month, Day, Year)

BUSIUSS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death 3. Time of Death Physician/ 29 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
0HI0 8. Date of Birth **Funeral** Months Days Hours 1 W 2 F JUNE 13, Year) Yrs. Director 287, 18, 5368 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No BALTIMORE MD ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3616 9th ST 21225 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If tes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: Completed Specify: 3 Widowed 4 Divorced WW II WHITE er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 SALESMAN FOOT WEAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 STEFAN BOBALIK ZUZANA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sortant: If item 27 is injury or other train SON JAMES TOND 1606 LORIMAR RD. GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2xx Cremation 3 Removal from State 4 Donation 5 Other (Specify) MDVETCEM CROWNSVILLE 6.24.2010 CROWNSVILLE, MD of Funeral Service Lice FINK FUNERAL HOME , P.A. K. GRECORY PUNK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 1. Enter the disec k, or heart lailure mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, it any leading to in mediate cause. Enter Underlying Examiner Date to (or as a monsequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Jinknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ours after death.

eral Director: After this certificate I filled in by the funeral director, pag Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title and address of pe completed cause of death (Item 23a) (Type, P EL.

State Registrar 400 L

Date filed (Month, Day, Year)

ni

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear Gloria Gloria L. Cassup 1:15P 16,2010 UNE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) 1922 Pennsylvania 8. Date of Birth (Month, Day, Year) March 7, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 M 2 F Months Days 185-14-9846 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Crownsville Anne Arundel 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 840 Valentine View 21032 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blontz Hilda Wilson Robert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 West Rd., Essex, MD. 21221 Howard Paul Cassup (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6/19/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liouse 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) I ☐Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760包 attending physician for use as the buria signed by the a d be detached f has certificate

Physician/Medical Completed Be Certification: To

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

death with

72 hours after

filed within

Pages 1 and 2 should be to perfer of Health and Mental

**Physician** 

/Medical

3altimore, Maryland 21215-0036

Director

Funeral

Completed

Be

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MD

Department of Health and Mental Hygiene important; if item 23a or 28a-f show amportant; if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examinar must be notified at once.

/Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Medical

State Registrar 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D57531

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

JUNE 17, 2010

30. Name and address diperson who completed cause of death (Item 23a) (Type, Print)

Hory Sut 204 pillersville, and 21108 8601 Veterans

Mohit Nego 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ une 2:30 PM Medical (if not institution, give street and number, Examiner 4c. County of Death atonsvi TIMOre 7. Age (In yrs. last birthday) **3** Yrs. If Under 1 Year If Under 24 Hrs. 8. **Funeral** Date of Birth 9 Birthplace (State or Foreign 1 □ M 2 🔀 F Hours eorgia Min. Director 28a-f show 10a, State filed within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2121 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Divorced Completed Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy jujury or other traumatic event, the Meones. Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) ည e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisters 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kicke 21. Signature of Funeral Service Light 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani U7 0CQ Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to lor as a consecuence on as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon Month Dav Year Yes 2 = M 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🔲 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes Other: ုင 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Acciden☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print AlGNIA Mp 1009 2/220 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** June 12 2010 03:30 AM Η. Carson James Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 7985 Tick Neck Road Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Funeral Days Country Hours Months 1 ☑ M 2 □ F 217-24-5906 26 1928 MD 81 Dec. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō filed within 72 hours after death with 7985 Tick Neck Road 21122 23a Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: \$ 3 ₩ Widowed 4 Divorced 'naturai" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within h and Mental Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Steel Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Η. James Carson Sr. Katherine Reckline ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at Important: If item 27 is any injury or other trauonce. 7985 Tick Neck Road, Pasadena, Cecilia K. Messenger (daughter) MD 21122 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June Date 15 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as eardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed les Due to (or as a consequence of) burialattending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s has autopsy performed? 1 □ Yes 2 No 2 MNo certificate Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 24 hours a Funeral C Hospital 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name and address of person

mountain Rd Plusadera mo. & 1124

who completed cause of death (Item 23a) (Type, Print)

Lever

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 Physician 5:10 JUNE 2010 Glenna V. Cutler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AGNIES HOSPITAL BALTIMORE N/A

9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) New Hampshire **Funeral** 1 □ M 2X F 77 July 16, 003-22-6761 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be retified at 1 ☐ Yes 2 🗓 No **Funeral Director** Woodstock Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21163 United States 2130 Ganton Green Unit G-2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: Be Completed by White 3 → Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lending Loan Officer nt of Health and Mental Hygir: If item 27 is marked other or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia С. Dumais Ralph В. Veysey မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2130 Ganton Green, Unit G-2, Woodstock, Maryland 21163 ace of Disposition (Name of Date 20c. Location - City or Town, State Dean W. Cutler, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State permit. Page: Department o Important: If any Injury or 6/19/2010 Metro Crematory, Inc. 6/19/2010 Baltimore, Maryland easton 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final GI 1 day **Physician** bleed disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hemorrhagic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical use as attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) o 9 Unknown rcate has been signed , page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: ₽ 2 ☐ Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18,2010 P74062 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A, KHATIR AVENUE 21220 LATOM 32. Registrar's Signature 31. Date filed (Month, Day, Year) back Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ uno 210 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number If Under If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🗶 F Months Hours Min 213-38-5121 91 1270271918 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? with 23a Funeral 2331 OLD COURT ROAD, #106 21208 USA items ! within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. th and Mental Hygiene.
?7 is marked other than "natural", traumatic event, the Medical Exa 3 N Widowed 4 Divorced Specify Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SEARS SALESWOMAN Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ISRAEL permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic PLEET LENA HOLLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRVIN I. COHEN/SON 2331 OLD COURT ROAD, #106, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State SHALOM MEMORIAL GDNS 6/23/2010 Donjation 5 Other (Specify) N. MIAMI, FL 22. Name and Address of Facility .EVINSON & BROS 8900 REISTERSTOWN ΜĎ ROAD, It 1 Enter the disease, or complications but caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifled in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 No 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**¹**□ No 1 🗌 Yes Yes 2 æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending work? Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifie. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (To

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Emmalynn Medical Dea1 2010 2:30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Hospice Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 😾 F Months Director 315-28-1918 Indiana Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12115 Hunters Lane 20852 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No 0 Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 ☒ Widowed 4 ☐ Divorced Completed Specify. Year or Dates **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t be t မ Dr. Ardie E. Jebkins Fannye Mackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeni Lynn DeBow (Daughter) 12115 Hunters Ln., Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Important: Il any injury or Ridgelawn Cemetery 4 Donation 5 Other (Specific 6/29/2010 Gary, IN <sup>22</sup> Name and Address of Facility Guy & Allen Funeral Directors 2959 W. 11th Ave., Gary, IN 46404 21. Signature of Funeral Service Ucens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Sepsis Medical Due to (or as a consequence of) Examiner Osteomyelitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Right Heel Ulcer been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Year Pregnant at time of death Month Day 4 ☐ Pregnant 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ w/o CVA, peripheral vascular disease 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 🗌 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral C Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 June 21, 2010

Registrar
DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Rd, Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

rar's Signature

Joseph Bindy, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's: Name (First, Middle, Last) 2. Date of Death Month Year **Physician** aross June 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 X M 2 🗆 F 214-45-5537 95 **Director** MD 14 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Director X□ Yes 2 □ No MD NA Baltimore must be notified or 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral U.S.A. 2948 Harford Road 21218 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 Yes 2 No
If Yes, Give
Year or Dates: Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed 9th grade na event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Lesli De Gross Troy Lee Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2948 Harford Road, Baltimore, Md 21218 Lesli De Gross-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State
4 Donation 5 ☐ Other (Specify) Memorial Park 6/26/2010 Woodlawn, Md Signature of Funeral Service Licensee, 22. Name and Address of Facility March F/H West once. 4300 Wabash Ave, Baltimore, Enter the disease, or complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) medullary **Physician** Renal LAYLINOMA /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury iner Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, ding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 3 Probably 4 Unknown 1 Tyes Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Jags Page page 1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending F after death. 1 Natural Injury 5 Pending investigation 1 Yes 2 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calvin Lee 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

JUN 23201

back

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 2017 04:10 pm Physician/ Darby Lawrence Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Towson Baltimore -Gilcrest Hospice Birthplace (State or Foreign Country)
 N.T 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Sept 09 1948 Months Days Hours 1 ☑ M 2 □ F NJ 61 Yrs 153-40-7245 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10a. State **Funeral Director** 1 🗆 Yes 2 屎 No Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21043 4000 Northridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Industry Finance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Claire Unknown Lawrence Darby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 608 Cook Drive, Salisbury, MD 21801 Anthony Darby (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
Metro Crematory Inc. 1 Durial 2 Cremation 3 Removal from State 23 June Baltimore, Maryland 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home 21. Signature of Funeral Service Lige 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or comprications that caused shock, or heart failure. List only one cause on each line o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between n et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Year in the past 12 months?
1 Yes 2 No 9 Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 Tyes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2**X** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signa N. CHARLES ST BALTIMORE, MD 2120 who completed cause of death (Item 23a) (Type, Print) 01 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4 Day JUNE 20°110 14:11 RM MARY DENNIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
PRINCE GEORGE'S **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours. Min. 4MPTh1Dgy,1Y9727 SOUTH CAROLINA 51-21-070 83 Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at within 72 hours after death with the Maryland Director r 28a-f sh notified PRINCE GEORGE FT. WASHINGTON MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be Funeral 7505 PUTT 20744 UNITED STATES items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces? Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ģ 1X Never Married 2 ☐ Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Divorced 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC DOMESTIC 9th Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ POR permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 PUTT RD FT. WASHINGTON, MD. 20744 MARY CRAFT/DAUGHTER Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) HARMONY MEM. CEMETERY! 6/16/10 LANDOVER, MD 22. Name and Address of Facility CAPITOL of Funeral Service MORTUAR ? 1425 MARYLAND AVE., NE WASH., DC 20002 complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1. Enter the disea shock, or heart failure. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown rease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 Alo Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Uchechi

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Opaigheogum.

DHMH 17 Rev 7/2009

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29c. License number P 0 0 3 7 0 6 6

29d. Date signed (Month, Day, Year) 06-07-2010

KON HILLA. #701 Oxon Hill MD 20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 14, 3. Time of Death Physician/ Year 2010 June 9:00 РΜ Elizabeth Evans Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata Care Center LaPlata Charles If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Hours 1 □ M 2 🏻 F Months LaPlata, 97 Director 299-22-0173 July 1912 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17811 Barney Drive 20607 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Charles Sampson Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17811 Barney Dr. Accokeek, MD 20607 Rosetta Evans - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖰 Burial 2 🗌 Cremation 3 🗐 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-17-10 Columbus, Ohio Union Cemetery Signatule | f Funeral Service Licens Name and Address of Facility choedinger Funeral Home 29 E. State St., Columbus 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IRULL Physician/ NAM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 15ABE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a s the burial-t by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signer should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Director: After that in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical

hours after within 24 hours a To the Funeral C

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 0006018 2010 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers GE-MAR KEI Duck 64 FF-RA 31. Date filed (Month, Day, Year) 32. Registra Signature

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#10e, perFH, G904, 6/23/2010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM#29c, perDVR, G904, 6/25/10, Gertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 11-20 AM 18 2010 ELESTINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Min Months Days Hours South Carolina 1 □ M 2 🖼 F Yrs. 2-183 100 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director 10g. Citizen of What Country? 10e-Street and Number 207 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GWYNN Oak UD100 riend 4723 Longhi 21207 rma 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ematory or other place) cemetery, c 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C Greene 5151 Baltmore Vaughw llene National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCHEROTIC **Physician** (OLDNAM 4 VASCULAR DISEAS /Medical Due to (or as a consequence of): xaminer BAS EAS C PERIPHENAL VASCULAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed GANGLENE HON EX EXTREMITIE burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 ■Unknown FERTENSION Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an ANAEMIA autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 
Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61439 18,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BALTIMOILE LIBERTY 2600 M. HEIGHTS 505 AN. ADEYEMIS! 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Pay June Maurice Foote 2010 3:00 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 303 Stable View Court Parkton Baltimore Social Security Number last birthday, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Days Hours Min. 212-40-0735 68 Mav 18, Yel 942 Maryland **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Baltimore Parkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Stable View Court 21120 U.S.A. within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates. <u>چ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pastor Church permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not known Dora Lee Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara C. Elson-daughter 30 Pine Bark Ct., Hunt Valley, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Lakemont Memorial 6/26/10 Davidsonville, MD 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> RUCK Towson Funeral Home, 1050 York Rd. Towson, Md. William G. Dau 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nefu Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital မ 1  $\square$  Yes 2 No Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending s after death.

J Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death 0 CV

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

var's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Registrar Certificate of		Reg. No.							
Physici dical Exami		Decedent's Name (First, Middle,Last)  MARIO ERNESTO GALO	Date of Death     Month Day Yea	3. Time of Death 1929 hrs							
dicai Exami	ilici		o. City, Town, or Location of Deatl	June 13, 2010 4c. County of Prince G	of Death						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  NONE 1 X M 2 F 21 Yrs.	June 6,1989								
w any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits						
ne Maryland or 28a-f show fied at once.	Director	Maryland Prince George's Riverdale  10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	1 X Yes 2 No						
ath with the Maryland items 23a or 28a-f sho st be notified at once	ral Dir		20737  Decedent of Hispanic Origin? ( S		- American Indian, Black,						
or de	y Funeral	1 Yes 2 No	s, specify Cuban, Mexican, Puerto ${ t Yes} \ \ 2 igsqcup { t No} \ \  extit{specify: } { t Sal}^+$		e, etc. White						
5-0036 led within 72 hours after death with the Maryland Hygient and cother than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'	s Usual Occupation (Give kind of st of working life. DO NOT use ret		siness/Industry						
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2127 uld be fil Mental I marked c event,	To Be	Jose Mario Galo  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	Rosa At Address (Street and Number or	n, State, Zip Code)							
and 2 sho ealth and em 27 is traumati	Γ,		4th Ave Riverda		City or Town, State						
Baltimore, MD 2121; permit. Pages I and 2 should be fil. Department of Health and Menial H Important: If item 27 is marked injury or other traumatic event;		1 K Burial 2 Cremation 3 Removal from State Crematory or other 4 Donation 5 Other Specify: Ojo de Agu.	a 06	/30/2010 Santa	Ana, El Salvad						
balt permit. Departs Import injury				ta Cruz Funeral :Washington, DC							
Physician Li Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Torso	e mode of dying, such as cardiac o	or respiratory arrest, shock, or hea	Approximate Interval Between Onset and Death						
LAdillilei		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
	Examiner	if any, leading to immediate  cause. Enter Underlying Cause  (Disease of injury that initiated or equally indicated or equally indicate									
recuted n and - transit	al Ex	d									
/ 60, icate be executed physician and the burial - transit	-	UNPENDED  AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high		23d. Date of							
box 68/ he death certific the attending points as the	Physician/	past 12 months?	I death 3 Ectopic pregna	ancy Month	Day Year						
ires that the signed by the detached	ò	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use contrib	bute to the cause of death?  Probably 4 Unknown						
s been should	ompleted			autopsy pi performed? de	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No						
VITAI KECC ysician: The lav his certificate ha director, page 2	Be Co	25. Was case referred to medical examiner? [Hospital: 4] Inpution: 2 FR/Outputions.	26.Place of Death (Check	only one)							
n or VI ding Physi a. After this funeral dir	욘	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of	ury 28c. Injury at Work?	g Home 5 Residence 6 v  28d. Describe how injury occurre Subject shot							
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	Certification:	Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined determined (Specify) Local Street 1 POUND: 1 Yes 2 No Suicide 1 Yes 2 No Suicide 1 Yes 2 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or For Town, State) 7779 Rings Road Hyattsville Miles									
the Hospit in 24 hour he Funera		4 Homicide determined (Specify) Local Street  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only 12 Wedical Examiner: On the basis of examination and/or investigation	d at the time, date and place, and		as stated.						
To t with To t	Medical	and manner stated.  29b/Signature and title of certifier	29c. License number O.C.M.E.		d (Month, Day, Year)						
2.		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn S									
4	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{une}^{Month}$  21. 2010 Gladden, Jr. Franklin 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Svkesville Fairhaven g. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, December 6 Sex 7. Age (In vrs. last birthday) Funeral Days 1 ₩ M 2 □ F 218-22-6693 **Director** 192 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is ansked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville 1 Yes 2X No Carrol1 Maryland 10e. Street and Number 10g, Citizen of What Country? Funeral 21784 7200 USA Third Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? Black. White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2x No Specify: Specify: 3√Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ruck Funeral Homes Funeral Director n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Franklin Gladden Clara Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allegheny Drive Eldersburg Maryland 21784 James F. Gladden, III (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Spher (Specify) Dulaney Valley Mem. Cdns. 6/28/2010 Timonium Maryland 21. Signature of Fund al Survio 22. Name and Address of Facility Towson, Mi. Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ heimers disease or condition resulting in death) CUS Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): ords, P.O. Box 68760 Krequires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director, After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed? Yes 2 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2-No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar

Ox,

Baltimore, Maryland 21215-0036

Records,

Division of Vital

Libert

1645

32. Registrar's Signature

dersburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tan MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 20, 2010 3:03 P м Graham John Fox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** <u>Stella Maris Hospice</u> Timonium 8. Date of Birth 7. Age (In vrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1<u>925</u> 1 🖁 M 2 🗆 F Months Hours (Month, Day, Connecticut 218-22-9243 **Director** 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No **Baltimore** Timonium Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. K 205 2525 Pot Spring Road, death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 1951–1953 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Executive <u>Insurance Industry</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Graham, Sr. Gillen James Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cockeysville, Maryland 24 Ivy Reach and 2 Son John Fox Graham, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 a ■ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) St. Mary S Govans Cemetery 6-24-2010 Maryland Baltimore 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 21. Sign Visiral Service icensee n of 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PARKINSON'S DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Learning Examine Due to (or as a consequence of) Cause (Disease or iinjury certificate be executed nding physician and use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE for use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy 1 Live Birth
4 Pregnant Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the hed 9 Unknown Division of Vital Records, P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? JOHN GRAHAM Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has infuneral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 9 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending thin 24 hours after death. the Funeral Director: Af mpleted filled in by the fu 1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the within To the 29c. License number 29b. Signature ar 201 1241 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Re

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert 61055 010 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BaltINOX Baltineye Universit Mary . Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 0871571926 147-12-6756 NJ Director 83 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8714 GROFFS MILL DRIVE 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian ıral", or iter I Examiner ı Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural", Specify: 3 Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WHOLESALE BUILDING College (1-4 or 5+) Elementary/Seconday (0-12) VICE PRESIDENT OF SALES MATERIALS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **GLASS** SARAH KROPNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **SHIRLEY** 8714 GROFFS MILL DRIVE, OWINGS MILLS, MD 21117 GLASS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK: 06/22/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Sign vure of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CAYCINONA Medical Due to (or as a consequence of) Examiner 10cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that lighted a control of the co Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence is a confidence of the funeral Director. attending physician and for use as the bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year ate has been signed by the a page 2 should be detached for 9 Unknown Part II. **Other significant conditions** contributing to de<u>a</u>th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Investigation 6 Could not be Accident 2 ☐ Accider 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29d. Date signed (Month, Day, Year) 2010 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar			Cer	tificate of L	Death			g. No.		19632
	Physicia	n/	1. Decedent's Name (First, Middle, Kizzie E1)		Hooper					Date of Death	, Day 2010 Ye	ar	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution,				4b, City, Town, or	Location of		une 10	4c. County of [	Death	11:30 AM
	/	CI	Anne Arunndel		,		Annapo		Douin		Anne Ar		le1
	Funeral			6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days			Date of Birth	9.		lace (State or Foreign
	Director		413-90-2765	1 □ M 2 🕂 F	58	Yrs.	Worthis Days	Tiodis	Ma	Month, Day, You iy 28,	1952 Te	nne	ssee
	at at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	ation					10	Od. Inside City Limits
	Aaryla 8a-f s tified	rect	MD Anne A	Arundel	Seve	ern							1 Yes 2 □ No
	a or 2 be no	ē.	10e. Street and Number				10f, Zip Code			10	g. Citizen of Wha	t Coun	try?
	h with	Funeral Director	314 Council Oa				21144				USA		
	r deat or iter iner	y Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 K Marr</li></ul>	Armed Fo	edent Ever in U.S prces? 2 🔯 No		Vas Decedent of H Yes, specify Cuba	ispanic Origir ın, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, V		
99	s afte ral", c Exan	q pe	3 Widowed 4 Divorced	If Yes, Giv Year or Da	/e	1	☐ Yes 2 ☑ No	Specify:			Specify:	Whi	te
Maryland 21215-0036	2 hour	Completed by		nt's Education st grade completed	,		ent's Usual Occup		of working	10	6b. Kind of Busin	ess Ind	lustry
121	thin 7; ane. than	)om	Elementary/Seconday (0-12)	College (1		Ìife. DO	O NOT use retired)	g		-	Nacre of a	. 17	
р 2	ed wi Hygie other ent, tl	Be (	17. Father's Name (First, Middle, L	1 3 ast)		Nurs	ie	18. Mother	's Name (Fir	st. Middle. Ma	Nursing	по	ille
lan	l be fil lental rked tic ev	잍	Milford Carrol	.1					·	an Hun	,		
ary	should and M is ma auma		19a. Informant's Name/Relationsh	ip (Type, Print) (H1	ısband)	19b. Mailin	g Address (Street a	and Number	or Rural Ro	ute Number, C	ity or Town, State	, Zip C	ode)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.		Stephen Boyd H	looper, Si	r.		Council	Oak Dr	. Sev				
Jore			20a. Method of Disposition  1 Burial 2 Cremation		State C	emetery, crem	sition (Name of natory or other plac		Date		0c. Location - Cit	-	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service L		Th		emetery  Name and Addres			19/10	Stanle		
Ba	permit. Departr Importa any injt		Juley 3	ende	e		, rame and radio				ey runer Luray, V		Home, Inc. 22835
П		(	23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that only one cause on ea	caused the death ach line.	h. Do not ente	r the mode of dyin	g, such as ca	ardiac or res	piratory arrest			Approximate Interval Between
	Physician/	77 1	Immediate Cause (Final disease or condition resulting in death)	a			18is					V	Onserand Death
عمر	Medical Examiner		resulting in death)	Due to	(or as a consequ	ience of):							
	WIE,	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consequ	ience of):						+	
	cuted and transit	xam	Cause (Disease or iiii)ury that initiated events	c. Duale	(or as a consequ							1	
	death certificate be executed re attending physician and ed for use as the burial-transit	dical Examiner	resulting in death) Last	Due to	(or as a consequ	ierice oi).							
/60				d							_	土	
( 687	certif anding use a	M/ng	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	71			23d. Date o	f delive	ry
Box		Physician/Me	in the past 12 months? 1 ☐ Yes 2 🗖 No 9 ☐ Unknown		nant at time of d		Other (specify)	, y			Month		Day Year
P.O.	The law requires that the arte has been signed by the page 2 should be detach	Phy	Part II. Other significant condition	ns contributing to c	death but not res	ulting in the u	nderlying cause giv	en in Part I.	T	23e. Did toba	cco use contribu	e to th	e cause of death?
	ires th signe d be c	d by				-				1 🗆 Yes			ably 4 🗆 Unknown
ord	v requ s been shoul	olete							-	24a. Was an	24b. Wer	autor	sy findings available
Sec.	he lav te has age 2	Completed								autopsy performe 1 \(\sum \) Yes 2	ed2 deat	h?	npletion of cause of 2  No
<u></u>	ian: T	Be C	25. Was case referred to medical examiner?	7			26. PI	ace of Death	(Check onl)		Z140] 1 =	163	2 🗆 110
<u> </u>	hysic this ce al dire	ည	1 🗆 Yes 2 💢 No		Inpatient 2			4 LI Nurs	sing Home	5 🗆 Residen	ce 6 🗆 Other (S	pecify)	
0	ding F h. After funera	Certificate:	27. Manner of Death  1 Natural 5 □ Pendin	9 .	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work M1	yat :? Yes 2 □ N		Describe how	injury occurred		
Division of Vital Records,	Atten ar deal ector: by the	rtifi	2 Accident Investig 3 Suicide 6 Could   4 Homicide determ	not be 28e. Place			et, factory, office	100 2 11	28f.		et and Number o	Rural	Route Number,
2	tal or irs afte al Dir led in			buildi	ing, etc. (Specify,					City or Town, S	State)		,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2	Medical		Physician: To the base xaminer: On the base Nurse Practioner:									d. ise(s) and manner stated. ited.
	To th To th												
	)		0	the committee	- 1 //	00-10-	<u> </u>	7602	-		0117		
			Su. Name and address of person v	3eth, MD	2001	Lesa) (Type, P	Parhwen	and	naboli	5 MD			
	Stat Registra	e ar	30. Name and address of person values (Month, Day, Year)	3 2010 32. F	Registrar's Signat	d.	backer						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 June Physician/ 18 6:25 p M Nelva Hobbs Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Pickersgill Towson If Under 1 Year If Under 24 Hrs,
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Febonth, Day, 1914 Mary land 96 Director 219-18-3717 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 ☐ Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 U.S.A. 615 Chestnut Avenue R209 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 XX Yes 2 X NG II
If Yes, Give WW II ģ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Work life. DO NOT use retired) Specialist in school Social 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Denninger Hobbs Minnie Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 West Rd., Suite 200, Towson, MD Gerald Marquez-friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/22/10 Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neral Pnysician/ disease or condition resulting in death) Medical Due o (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1  $\square$  Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 30. Name and address of person who completed cause of

31. Date filed (Month, Day, Year,

death (Item 23a) (Type, Print)

32. Regis

hades St. Balto, md 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02(U M 6 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** M 2 □ F Months Days Hours Min. (Month, Day, Ye April 08 Country) Director 214-48-1603 63 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items marked other than "natural". 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗵 No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7913 Red Globe Court 21144 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White Completed 3 ☐ Widowed 4 ☒ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense Logistics Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Heath Cleo Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Adkins (daughter) 9304 Sea Horse Court, Edgemere, MD 21219 Date 22 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 🙀 Cremation 3 D Removal from State June Metro Crematory Inc. 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland 21. Signature of Funeral Service Micenses 22. Name and Address of Facility Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Immediate Cause (Final Ph\_sician/ disease or condition (mi Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performe certificate 2 🗀 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: HOSPICE 1 ☐ Yes 2 ☑ No |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this House 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2  $\square$  No Accident Investigation within 24 hours after death

To the Funeral Director; completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h. Signature and title of 30 Name and address of person se of death (Item 23a) (Type, Print) ho completed oau

DHMH 17 Rev 7/2009

State Registrar ت

Registrat's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 9635 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 2010 **Physician** JÜNE 7:11P M **HOFFMAN** LILLIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2903 FALLSTAFF ROAD, #408 BALTIMORE N/A Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 08/08/1908 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 1 □ M 2 🕱 F  $101^{\,\mathrm{Yrs}}$ MD 212-03-0763 Director Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director 28a-f MD N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 2903 FALLSTAFF ROAD, #408 23a 21209 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) than College (1-4or 5+) U.S. POSTAL SERVICE STENOGRAPHER h and Mental Hygien 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOFFMAN FRIEDA KATZENELL ISRAEL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2020 WISCONSIN AVENUE NORTH, GOLDEN VALLEY, MN 55427 EARL HOFFMAN / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BNAI ISRAEL CONG. 06/21/2010 BALTIMORE, MD 21. Signalur Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause q) as h line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ns disease or condition resulting in death) / /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for selection according of Examiner burial-transit and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other signifigant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed been a 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy certificate 1 □Yes 2 No 25. Was case referred to medica examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Desidence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification:

certificate be executed Box 68760, P.O. Division of Vital Records,

Saltimore, Maryland 21215-0036

Hospital or Attending Physician: After this funeral 24 hours after death. Pruneral Director: A filled in by

5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be

3 Suicide 4 Homicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated 30 CKN 29b. Signature and title of certifier

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who

npleted cause of death (Item 23a) (Type, Print) 32. Regist ar's Signature 31. Date filed (Month, Day, Year)

State Registrar

within 2

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN/SONI 20 /ea /Medical 4a. Facility Name, (If not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death BALTIMORE, SECOURS HOS PITAZ If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Director 69 215-72-0301 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 2 should be filed within 72 hours after death with the Marylar I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it is marked be notified in 28a-f show 10d. Inside City Limits Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4729 Williston Street U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 
Yes 2 
No 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unknown Nurse Assistant Nursing Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles Johnson Eleanor Cager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Williams-Daughter 4729 Williston Street, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/25/2010 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 1. Sign ture of Funeral Service L 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition remaining in death) SEPSI **Physician** /Medical Due to (or as a consequence of): Examiner DISEASE RENAL Sequentially list conditions, if any, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine that the death certificate be executed and Due to (or as a consequence of) burial-1 Box 68760, physician Physician/Medical attending properties of a second IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HY PERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SMALL SOWEL GANGRENT RESECTION AND 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page ALASTO MOS 15 certificate Division of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ※ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after death.

Pe Funeral Director: Affetely filled in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

Hospital or Attending completely within 2

> State Registrar

31. Date filed (Month, Day, Year) 2 3 20 10 Register's Signature

V. MUBHAELIMO

moghell, m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BALTINUNE,

29c. License number

014949

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** une 0510 AM 2010 <u>Dolores J. Jacobs</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner -anes saltumore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Davs Hours Director 6/17/43 Maryland 217-40-2093 67 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be relified at Director 1 XYes 2 ☐ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 302 Marvdell Road 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 7 Is marked other traumatic event, 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ang. Be ပ John Rodemeyer Dorothy Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert C. Jacobs / Husband 302 Marydell Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Ma Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 6/23/10 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lipensee ug 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or e shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 06monts **Physician** +ack Rena /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): certificate be Physician/Medical Pai use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 🗷 No the detached the 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEBREYES

21215-0036

Baltimore, Maryland

Вох

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Records,

Vital

of

29d. Date signed (Month, Day, Year)

altimore, MD.

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE DANIEL T. KUCHTA 2010 5:27 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Davs Hours Min MARYLAND 217-16-7604 Director 87 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 XNo PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3339 WILLOUGHBY ROAD 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WWII Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ODDE. Elementary/Seconday (0-12) College (1-4 or 5+) BOOK PRINTER PRINTING 10TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WALTER KUCHTA IDA GRYZBOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNICE KUCHTA/WIFE 3339 WILLOUGHBY RD. BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS CEM. 6/23/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO0217 <u>8521 LOCH RAVEN BLVD.</u> TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, NOSTAGE RENAL DISEASE WITES Medical resulting in death) Due to (or as a conse wence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 🚾 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide completed filled in by determined Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D64395 THNE-18,2010 ax1

State Registrar

6701 NCHARLESST, SNITE 4105 BALTMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIEUK DOBAMAN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 4b per MD G911 1/31/11 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16th 2010 11:00 AM Α. Florence Lemon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manes DITO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 □ M 2 🔽 F 241-94-8289 56 06 Director NC Usual Residence of Decedent 10c City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinational beautified at 1 Yes 2 □ No Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2024 Wilkins Ave 21223 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ò Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs+ FRI Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Dillard McKoy Mary Lemon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McKoy-Mother 20a. Method of Disposition 1413 Church Street, Wilmington NC 28401 e of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2010 Wilmington, NC Calvary 21. Si vatur of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Par I1. Enter the disease, or complications that Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lei ure. List only one cause on each line.

Immediate Cause (Fin disease or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner RENAL FAILURE ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine IVER CUTE and attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Anemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 ☐Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Set 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending 1 Natural 5 Pending investigation n 24 hours after death.
he Funeral Director: Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the the To the within ? To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16th 2010 me and address of person who completed cause of death (Item 23a) (Type, Print)

MALIA HO (LACES = 100 CATO ATON AVENUE, BALTINOKE, MD 21229. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Ludwig Lydia 19 4:55 AM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgamery Rockville Hebrew Hame of Greater Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex . Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) 1 ☐ M 2 🔀 F Months Days Hours Min Director 579-42-5628 Germany 92 March 1918 Usual Residence of Decedent fshow ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" Application or other traumatic events. Funeral 20852 USA 6111 Montrose Road #908 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Unk College (1-4 or 5+) Private Accounting Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Marie Schindler 2 Emil Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14510 Homecrest Rd #2004, Silver Spring, MD 20906 Gabriele Ludwig Johnson (Daug) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Svc 6/22/2010 Hanover, MD 21. Si natu o Funeral Service Licensee 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Latimore Funeral Services, P.A. 9013 Annapolis Road, Lanham MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or immery Due to (or as a consequence of): burial-transi Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ρģ in the past 12 Month Year 1 ☐ Yes 2 🛣 No 9 ☐ Unknown the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, or Attending Physician: The law requires Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Kidney Disease autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral dire 1 Tes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

pa

Leszek Karowiec, M.D.

31. Date filed (Month, Day, Year) JUN 2 3 2010

D0035859

501 N. Frederick Avenue, Gaithersburg, MD 20877

June 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June Physician/ Richard Daniel Lovell 2010 4:50 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 1126 Hoods Mill Road Cooksville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 X M 2 □ F . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours March Day, Year 1921 Pennsylvania 215-14-9400 89 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 S. Morerick Avenue 21228 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian med Forces?

Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Year or Dates. WW Specify: White 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bottling Equipment Machinist Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic ever 2 Charles Wilson Lovell Laurine Brink permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VTKathryn J. Lovell, daughter Vine Street Brattleboro. 05301 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Metro Crematory, Inc. 06/19/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNab 22. Name and Address of Facility Cremation Society of MD, Inc. EMEM Ser 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Esqueritally list on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No ed by the a detached f 9 Unknown 9 Unknown ts been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6X Other Specify S Residence 2 No Hospital 은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending s after death.

I Director: A pd in by the fu death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct Completed filled in b City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number June 19, 2010 30. Name and address of person who completed cause of death (Item 3a) (Type, Print 516 N. Rolling Road M.D. Marcelino Albuerne. Catonsville, MD 21228

State

Registrar

31. Date filed (Month, Day, Year

JUN 2 3 2010

32. Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month ev Un 0 Facility Name (If not institution, give street and number) 4b. City, Town, 4c. County of Death Leh SOLKINGOI 139 Itimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 30, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days <sup>Year)</sup> 1921 Hours Months 1 M 2 X F June Ohio 88 273-16-7805 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🕅 No Oak Baltimore Gwynn Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 United States 6825 Campbell Road Apt9P Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2X No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Smithsonain Executive Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Engelbrecht Kar1 Trautmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Campbell Road, Apt 9P, Gwynn Oak, Maryland 21207 <u>William C. Loerke, Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. of Fyneral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to or as a conse uence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy Live birth 2 Petal death Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) TYES 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

**Physician** /Medical Examiner

Department of Health al Important: If item 27 is any injury or other trau

Pages 1

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

72 hours after

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Baltimore, Maryland 21215-0036

physician

P.O. I

Division of Vital Records,

To the Hospital or Attending Physician:

funeral

s after dea. ral Director; After filled in by

within 24 hours a

To the Funeral I

completely filled

Medical

Examine use as the burial-tran Physician/Medical the detached ò signed to à Completed page 2 s certificate has Be Certification: To After this

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical		26. Place of Death (Check only one)					
examiner? 1 ☐ Yes 2(DaNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	lnjury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No					
3 Suicide 6 Could not be determined		ffice 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a, Certifier Certifying Ph	nvsician: To the best of my knowledge, death occurred at	the time, date and place, and due to the cause(s) and manner as stated.					

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certife

29c. License number

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8, 19b, State of Maryland Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 09=16PM DAVID RONALD LEVIN TUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENESIS MULTI-CARE TOWSON BALTIMORE Social Security Number 1958 Birthplace (State or Foreign Country)
 MD If Under 24 Hrs. Funeral 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth Days 06/18/<del>2010</del> 220-48-9247 52 Yrs. Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2 X No BALTIMORE BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 617 LEAFYDALE TERRACE <u> 21208</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) BENEFITS CLERK ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 702 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

617 LEAFYDALF TERRACE SALE LEVIN BERNARD SAFFRON of Health and Mer of Health and Mer fitem 27 is mark rother traumatio 19a. Informant's Name/Relationship (Type, Print) NANCY SHUALY / SISTER BALTIMORE. MD 21208 20b. Place of Disposition (Name of OHE Place)
BETH ISRAEL CEMETE 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it 1 X Burial 2 Cremation 3 Removal from State CEMETERY 06/22/2010 BALTIMORE, MD injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ARDIO MY OPATHY disease or condition Medical resulting in death) Due to (or as a consequence of Examiner FAILURE HEART Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner DYSTROPHI ROGRESSIVE Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): RE Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month 1 Yes 2 No 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Chanic 2 No Division of Vital To Be 25. as case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANTIAGO RD SHAKUN MALA 9650

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2010 Physician/ June Clifford McGhee Warren 12, 3:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Sept. 3, Year) 1 1 M 2 1 F West Virginia 300-34-1419 70 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at death with the Maryland Director 1x Yes 2 □ No MD Prince George's District Heights ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2012 Brewton Street 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō 1 X Never Married 2 ☐ Married 1 Yes If Yes, Give Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", 3 Widowed 4 Divorced **Black** Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Erskin McGhee Ruby Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford McGhee 3455 Street Road Rensalem, PA 19020 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 6-19-10 4 Donation 5 Other (Specify) Gethsemane Mem. Gdns. Oak Hill, WV 22. Name and Address of Facility Ritchie & Johnson Funeral Home Sign tur of Funeral Service icensee Illen Fayette St. Beckley, WV 25801 748 S. part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. o. line. Approximate Interval Between Immediate Cause (Final Pnysician/ Medical resulting in death) **Examiner** Seque tially list so differs, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 M No Hospital: Other: Certificate: To | 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa, MD 7503 Surratts Road Clinton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irwin J. Macomber *0020* M une Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 93 Months Days May 2, Day 917 215-09-5642 **Director New** York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location
Parkville 10d. Inside City Limits Director Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2326 Foster Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Completed by 1 XYes 2 □ N If Yes, Give Year or Dates. 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Manager Bendix Avionics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Sinsabaugh Hugh Macomber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Hefner/ Daughter 1075 Raver Lane Glen Rock, Pennsylvania 17327 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗡 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 6/24/2010 Baltimore Maryland . Name and Address of Facility eonard J. Ruck, Inc. 305 Harford Road Baltimore Maryland 21214 21, Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph sician/ arrhythmia Medical resulting in death) Due to (or as a o insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 W Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury ė 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Certifical 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate h

Kathleen 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

only one)

Loch Paven Blud, Baltimore, Md 21239

30. Name and address of person who completed cayse of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOC62689

June 22, 2010

29c. License number

10-04675 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Edward Matthews** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Matthews 1133 hrs William **Medical Examiner** award June 21, 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death NIA 3103 Wolcott Avenue Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6 Sex **Funeral** Foreign Country) Days Hours Min. 108 Director 212.42.9423 M 2 F Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3103 Wolcott Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Yes Black f YAS, Give Year Widowed Divorced 1 Yes 2 No specify: Specify: 3 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than awn Care Baltimore, MD 21215-0036 Ivee Kennover Ith grade of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) luroin Be DOOWNE Matthewis Lora 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 NOI COTT AVENUE Sandra V. Matthews 13a Himore MD 21216 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State crematory or other place) Owings Mills, MD 200 ment ( Torest Jarvisov Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licen Jaugen C Load Fandallstown MD 21133 Approximate Interval 23a. Part I/Enten the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - tran Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No Yes 2 V No Yes the Hospital or Attending Physician: Thin 24 hours after death.

The Funeral Director: After this certification in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa

DHMH 17 Rev 1/2001 OCME 2006

Registrar

29b. Signature and title of certifier

31. Date filed (Month

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

**Assistant Medical Examiner** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / Department of He	ealth and Mental Hygiene

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George Michael	Nol	ole 1- For State	State o	f Maryla		partment d <i>ertificate d</i>			Mental H	lygiene		- U i	0	19648
Physicia	an/	Registrar  1. Decedent's Name (First, Manual Control of the Contro	1iddle.Last)					107		2. Date of D	Reg. N eath	lo.		3. Time of Death
Medical Exami			ederi	ck No	ble					Month June 17	Da 7, <b>201</b> 0	y Year 0		1515 hrs
		4a. Facility Name (if not insti	tution, give s				4b. City	, Town, or L	ocation of Deat			4c. County of I	Death	
		Prince George's H	ospital Ce	enter			Che	verly				Prince Ge	orge'	s
Funeral		5. Social Security Number	6. Sex		7. Age (In yr	s. last birthday)	If Un Mon	ths Days	If Under 24Hr Hours Mir	_	Birth(M	IM/DD/YYYY)	9. Birth oreigh	place (State or Washington,
Director		218-25-3080	1 <u>X</u> N	1 2 F	2:	3 <u>Y</u>		uis Days	Tiodis Will	04/1	5/19		Cou	D.C.
<u> </u>		Usual Residence of Deceder 10a, State 10b, Cou			10c C	ity. Town or Loca	ition						_	10d. Inside City Limits
ow any			airfax	,	100.0		ston							1 Yes 2 No
Maryland 28a-f show d at once.	ctor	10e. Street and Number	411142	•		- AC		ip Code			10a. C	Citizen of What		
vith the Maryland s 23a or 28a-f show 2 notified at once.	Director	2066 Lake Aud	ubon (	ourt.				20191	ı					
with tl	erall	11. Marital Status		12. Was Dec	edent Ever in			dent of Hisp	anic Origin? ( S		Uni No-		tate Americ	an Indian, Black,
leath r	Fune	1 X Never Married 2	Married	Armed Fo	orces?		Yes, spe	cify Cuban,	Mexican, Puerto	o Rican, etc.)		White, e	itc.	
after d	by F	3 Widowed 4	Divorced If	Yes, Give Year		1	Yes	2X No	specify:			Specify:	Wh	ite
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36 in 72 han "	plet	Elementary/Secondary (0-	12)	College (1	-4 or 5+)							(		
5-0036 Iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Mid	dle. Last)	2			Stude		3.Mother's Name	e (First, Middle	e, Maide	N/A en Surname)	—	
215 e files tal Hy ked o	BeC	Roger F. No							Katherin		ırra			
2121 ould be fi d Mental I s marked	2	19a. Informant's Name/Relat		e, Print )					and Number or	Rural Route N	lumber,	City or Town,		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		Roger F. Nobl	e, Fat	her_					bon Cou		stor	n, Virg	ini	a 20191
s I an of Hea		20a. Method of Disposition  1 Burial 2 X Crema	ntion 3	Removal fro		<ul> <li>b. Place of Dispo crematory or o</li> </ul>				Date		c. Location - Ci	•	•
Page Page ment o		4 Donation 5 Othe	r Specify:		Mε	etro Cre	nator	cy, In	c. 6/2	1/2010	Ba	altimor	e,_	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Ser	vice Lice vie	• Amand	la Heas	ston   22.	Name an	d Address o	of FacilityCre	mation	Soc	iety of	Mar	yland, Inc
	2.33	23a, Part I, Enter the disease	or complica	ations that ca	aused the dea									nd 21228 Approximate Interval
Physician /Medical		failure. List only one ca	use on each	line.				· ,		,				Between Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in deat			consequence	und of Head e of):	_						$\dashv$	
		Sequentially list conditions,	b											
	iner	if any, leading to immediate cause. Enter Underlying Ca	ise	e to (or as a	consequence	e of):								
,0. =	xam	(Disease or injury that initiate events resulting in death) La		e to (or as a	consequence	e of):							$\dashv$	
be executed incian and unial - transit	al Ex		d										_	
	edical	UNPENDED		AMENDED										
Sox 6876( leath certificate e attending phy-	2	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, o	outcome of pri		etal death	3	Ectopic pregna	ancv	2	23d. Date of de Month	livery Da	y Year
x 68 th cert	.2	past 12 months?			ant at time of	dooth -	ther (Sp							
Box te death of the atten	Physi			9 Unkno						Los ni				
S, P.O.  uires that the 1 signed by 1 d be detache	by F	Part II. Other significant con	iditions co	ontributing to	death but no	t resulting in the	underlyir	ig cause giv	ren in Part I.					e cause of death? bly 4 Unknown
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tal Rec	5	-								1 🗸 Yes	s 2	No 1 <b>✓</b>	Yes	2 No
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ion c tending eath. tor: Af	Ęį		ending	Jun 17, 2	Day Year) 2010	0359 hrs		1 Ye	s 2 🗸 No	Subject sh	not			
Division ospital or Attendin hours after death.	Certification:		ould not be	28e. Place	of Injury - At	home, farm, stre	et, factor	y, office bui	lding, etc.				or Rura	Route Number, City
Divoital o	ë	Juicide	etermined	(Specify)	Farm					or Town 2208 Garrit	, State) y Road	l, St. Leonard	is, MC	)
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To the Hos within 24 h To the Fur completely	Medical	2 🛡	ar	n the basis o nd ma <mark>nne</mark> r st		and/or investiga				at the time, da				
	Σ	29b. Signature and title of ce	titier /	1	201		29	C. License				d. Date signed		h, Day, Year)
		Allenk	lowney	1.11	2			O.C.M	·E.		Ju	ine 20, 201	<i>.</i>	
5		30. Name and address of per Melissa Brassell, M			e of death (Ite dical Exam		enn S	treet Ba	ltimore, MD	21201				
	ate	31. Date filed (Month, Day Ye	ar)	0				, Ба					—	
Regist		JUN 2 3 201	0 4	enva	p. 1	atur								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Katherine Louise Powel1 8:40 P M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockvil⊥e If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr. 2, 1939 1 M 2 K F Months Days Hours <sup>Country)</sup> Virginia Director 71 230-66-2847 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director VA 1 X Yes 2 No Virginia Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23464 636 Oleander Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 😾 No 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give 3 - Widowed 4 X Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) City of 12 Coordinator Virginia Beach Be KATHENNE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Alice Reinecke Stanley H. Powell Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 5204 Waterview Drive, Rockville, MD Mark Lee Badger / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Grove
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ onation 5 ☐ Other (Specify) 6-26-2010 Williamsburg, 21. Sign ture of Fu eral Service Lice ee Snellings Funeral Home 22. Name and Address of Facility 23701 5605 Portsmouth Blvd., Portsmouth, VA ruce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shock disease or condition resulting in death) 16415 Medical Due to (or as a consequence of): Examiner hematoma wall abdomina Gaquentiany list scrintions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by carcinoma 1 Tes 2 ☐ No 3 ☐ Probably 4 → Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No After this certification funeral director, p Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Madran an pount D0062562 JUNE 2010 181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD Madhavi Hubbly, M. D. 31. Date filed (Month, Day, Year) JUN 2 3 2010 32. Registrar's Signature State Registrar

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21215-0036

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HERIN

Division of Vital Records, P.O. Box 68760

Daniel Payne UNK UNK

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate of I		id Wieritar i		eg. No.		
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Lass				- <del>-</del>	2. Date of Dea Month	Day Yea	ar	3. Time of Death 0932 hrs
A Caroar Examina		Daniel S.  4a. Facility Name (if not institution, giv  St. Agnes Hospital	Payne e street and number)	46	. City, Town, o	or Location of Dea	June 20, 2	4c. County	of Death	
Funeral Director		5. Social Security Number 218-64-0370 6. Security Number 1 X	7. Age (In yrs. Mark 1975) 7. Age (In yrs. Mark	last birthday) Yrs.	If Under 1 Ye Months Da		-	th (MM/DD/YYYY 3/1955	Foreign	
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State 10b. County MD NA		Town or Location	1					10d. Inside City Limits 1 X Yes 2 No
the Marylan a or 28a-f sl	Director	10e. Street and Number 2410 WINCHEST	ER St. Apt.		10f. Zip Code 212]	L6	1	0g. Citizen of Wi USA	nat Coun	try?
r death with or items 23	Funeral	11. Marital Status 1 Never Married 2 Married	1 Yes 2 X No	If Yes	, specify Cuba	lispanic Origin? ( \$ an, Mexican, Puert		White	e, etc.	can Indian, Black,
2 hours afte "natural",	6	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. Decedent's during mos	t of working lif	ation (Give kind of e. DO NOT use re	tired)	Specify:	isiness/Ir	
0036 within jiene.	Completed	9th	N A	Sanit	ation	Worke				moval Co.
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antic event, the Medisa	B S	17. Father's Name (First, Middle, Last) Robert Payne				Franc	ne (First, Middle, M es Jef	ferson		
D 2121 (Should be fill and Mental File marked latic event, 1)	- 6	19a. Informant's Name/Relationship (T		100	•	eet and Number or		· ·		
e, MD 1 and 2 sho Health and item 27 is	ŀ	Gerleane Robin 20a. Method of Disposition	20b.	Place of Disposition	on (Name of c	rd Road emetery,	Date Date	20c. Location -		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	-	1 X Burial 2 Cremation 3 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licen	Dr	ruid Ri	dge Ce		/26/10	Pikesvi		
		Blyma B	Keke		rch F		0 Wabas			lto., MD
Physician Line di Lil Examiner	X	The state of the s		so	mode of dying	g, such as cardiac	or respiratory arre	est, shock, or hea	art	Approximate Interval Between Onset and Death
		Sequentially list conditions, b.		,						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of							
cuted	Ä	events resulting in death) Last d.	Due to (or as a consequence of							
60, tate be executed bhysician and re burial - transit	Medical	UNPENDED	AMENDED					Lood Bata at	1-1:	
ox 687 eath certific	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg  1 Live birth  4 Pregnant at time of de	2 Fetal	death 3	Ectopic pregn	nancy	23d. Date of Month	Di	ay Year
that the daned by the detached		Part II. Other significant conditions		esulting in the und	derlying cause	given in Part I.		bacco use contri		he cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  The law requires that the breath signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed by						24a. Was a autop	an 24b. V sy p med? d	Vere autorior to co	opsy findings available ompletion of cause of
Vital Rec		25. Was case referred to medical			26.Plac	e of Death (Check	1 Yes :	2 No 1	✓ Yes	3 2 No
f Vita Physicis r this ce	To Be	1 Yes 2 No		ER/Outpatient				Residence 6	Other:	
on of cending Pheath.	ij	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month Day, Year) FOUND: Jun 20, 2010	28b. Time of Inju FOUND: 0905 hrs	· 1	ury at Work? Yes 2 ✓ No	Subject shot		30	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At h	ome, farm, street,	factory, office	building, etc.	28f. Location (S or Town, S 2500 Block of	tate)		al Route Number, City altimore, MD
To the Hospital within 24 hours To the Funeral completely filled	edical (	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	<ul><li>an: To the best of my knowled</li><li>On the basis of examination a</li></ul>	ge, death occurre	d at the time, on, in my opinio	date and place, an n, death occurred	d due to the cause at the time, date	e(s) and manner and place, and d	as stated ue to the	d. cause(s)
To with Con	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	·	29d. Date signe	ed (Mon	
	-	30. Name and address of person who	completed cause of death (Item	1 23a)	0.0	.M.E.		June 21, 20		
		Carol Allan, MD Assista	nt Medical Examiner	111 Penn St		nore, MD 2120	01			
Sta Registr	13.7	31. Date filed (Month, Day, Year) 2 3	2010 32. Registrar's Signatu	B. 4	arke					

DHMH 17 Rev 1/2001

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 18 Physician/ 2010 :58a. Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AVENUE 8. Date of Birth
(Month, Day, Year)
01 01 50 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days 1 ☐ M 2X F Hours Director 212-50-6369 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🌠 Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21207 U.S.A. 5520 Liberty Heights Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3√ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service's |State of Maryland 8th grade na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dorothy Equhank Ronnie Santiful 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21207 19a. Informant's Name/Relationship (Type, Print) 5520 Liberty Heights Ave, Baltimore, Monica Graham-Daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State On-Site 6/25/2010 Baltimore, ☐ Donation 5 ☐ Other (Specify) Signa vre o Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore. Knawn Ave. 2 a. Pa / 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im Late Cause (Final disease or condition Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No certificate Yes ours after death.

eral Director: After this certifics filled in by the funeral director, t 25. Was case referred to medical examiner?
1 Ves 2 No 26. Place of Death (Check only one) **Division of Vital** Be Other: မ 1 Inpatient 2 NER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) W- Belvede 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State 2010 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21 ay 2010 June 2:24 P M Pugh Lark Warner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Davs Hours west Virginia Director 09-07-1949 214-62-3502 60 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 3607 Gibbons Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the state State of Maryland Telecommunication Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o မ Earl Eugene Warner Marie Charlotte Maver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Cameron M. Warner-Pugh Son Chesapeake Beach, MD 20732 2829 McDuff Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State = 5 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: I any injury o Hilltop Service Corporation 6-23-2010 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter no disease, or comshock, or hear failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) / Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

Within 24 hours after death.

The Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death
Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nume Practioner: To the best of my knowledge, dest thre (Mexice) entitle suits bine read of the extrement and the berringer

State Registrar

31. Date filed (Month, Day, Year)

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eted cause of death (Item 23a) (Type, Print) 6701 N.C upe 21,2010

HARUS ST BALTIMORE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** eddico 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner kesville 5 Car oper 2 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 22, 19 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 ▼ M 2 □ F 1943 215-44-1588 66 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show 1 ☐ Yes 2X No "natural", or Items 23a or 28a-f sh dical Examiner must be notifled Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 413 Westside Boulevard Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after ( Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 🙀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
It is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Peddicord George Howard Elizabeth Barbara Pistel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Westside Boulevard, Catonsville, MD 21228
lace of Disposition (Name of Date 20c. Location - City or Town, State Department of Health Important: If item 27 Kenneth R. Hixon, Jr., Personal Rep or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o Lake View Memorial Park 6/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service LicenseeAmanda Heaston 301 Frederick Road, Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ew Jement1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year for Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9☐Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ò 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has 1 Yes 2 No Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Director: After (Month, Day Year) Division 1 Natural 5 | Pending Injury 1 □ Yes 2 □ No Investigation death. 2 Accident completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

M address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

11998813

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . Minib 18°, 201°0° Rellihan Zenobia 6:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Assisted Living Catonsville Baltimore 5. Social Security Number 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Mary Land NOV 27 220-01-3717 Director 90 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transmission. ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1401 Valley View Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2 X No 1 ☐ Yes 2 👿 No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unk. Daniel Altland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric W. Rellihan, son 569 West Drive Severna Park, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metro Crematory, Inc. 06/19/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNahl 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-traits that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Yes 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death. To the Funeral Director: After this certificate has t autopsy 1 Yes 2 No 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Living 2 No မ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 19, 2010 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar

OGGREPS BAITMO 21228

10-04573 Daniel James Russell

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2010 1	3	5	5	1 1 1
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		1- For State Registrar			Certific	ate of l	Death			F	Reg. No.		_	
Physicia	an/	1. Decedent's Name (First, Midd							2	2. Date of De Month	ath Day	Year		3. Time of Death
ledical Exami	ner	Daniel James								June 16,		0	(Daath	2215 hrs
		4a. Facility Name (if not institution St. Joseph's Hospital		number)			. City, Town, or Towson	Location o	r Death			: County of Baltimore		ntv
5		Social Security Number	6. Sex	7 Age (In	yrs. last bin		If Under 1 Yea	r If Unde	r 24Hrs.	8. Date of B				nplace (State or
Funeral Director	J				•		Months Day				,		Foreign	
	1	025-28-1240 Usual Residence of Decedent	1X M 2		21	Yrs.			<u> </u>	06/8/	1989	<i></i>		nt California
any		10a. State 10b. County		100	. City, Town	or Location	n						T	10d. Inside City Limits
	L	Maryland	N/A			Ba	1timore	<u>.</u>						1 X Yes 2 No
Maryland 28a-f show datonce.	윉	10e. Street and Number					10f. Zip Code				10g. Citi	izen of Wh	at Count	try?
the M	Director	717 Walker Av	enue				21	212		Ì	Uni	ted	Stat	tes
with ns 23.	a	11. Marital Status	12. Was [	Decedent Eve	r in U.S.		Decedent of Hi	spanic Orig				14. Race	- Americ	an Indian, Black,
death r iten	uneral	1 X Never Married 2 M	larried Armed	Forces?	No	IT Yes	s, specify Cuba	n, Mexican,	Puerto R	tican, etc.)		White		
after al", o	by F		vorced If Yes, Give or Dates:				res 2 X No					Specify:		
5-0036 led within 72 hours after death with the Maryland Hygiene. I other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at onec		15. Decedent's Education (Spe					s Usual Occupa st of working life				16b. l	Kind of Bus	siness/In	dustry
)36 thin 72. te. than "	ompleted	Elementary/Secondary (0-12)	College	(1-4 or 5+)	l co	mmero	cial Ro	ofer			Cor	nstru	atio	n
OO.	E O	17. Father's Name (First, Middle	Last)			/IIIIICE (	Lai Ko		s Name (I	First, Middle,				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C		ssell, Sı	_				Lori		erner				
212 Ment Ment mark		19a. Informant's Name/Relations		- •	19	b. Mailing /	Address (Stre	et and Num			ımber, C	ity or Towr	, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Daniel J Russel	ll, Sr.,	Father	40	07 We	st Suns	et Av	enue	, Gree	ensb	oro.	MD 2	21639
e, le, land Healt Fitem		20a. Method of Disposition  1 Burial 2 Cremation			20b. Place cremat	of Dispositi	on (Name of ce	metery,		Date	20c.	Location -	City or T	rown, State
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service	Licensee Amar	nda Hea	ston	22. Na	me and Addres	s of Facility	Cren	nation	Soc	iety	of M	Maryland aryland,Inc
E F G F W		Smanle DA	ear for			299	Freder	ick Ro	oad,	Balti	more	, Mai	cyla	nd 21228
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		or condition resulting in death)	Due to (or a	s a conseque	ence of):									
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o, o, e be e burial	/Medical	IF FEMALE:	AMENDE 23a,	27,28a es, outcome o	-f, po	er <u>ME</u>	g905 7	/1/10	TT		1 23	d. Date of	delivery	
		23b. Was decedent pregnant in the past 12 months?		e birth	pregnancy	2 Feta	death 3	Ectopic	pregnan	су	120	Month		ay Year
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Division spital or Attendi	Certification:	dete	ald not be Speci				idence	g,		or Town,	State)	717 W. D	a1ke	al Route Number, City r Ave
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To To	Mec	29b. Signature and title of certific	and manne	Stated.	1 11.57	Al	29c. Licen	se number			29d.	Date signe	ed (Mon	th, Day, Year)
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4		30. Name and address of person	n who completed o	ause of death	(Item 23a)									
V		Victor Weedn MD JD	Assistant i	Medical Ex	aminer	111 Pe	enn Street, I	Baltimore	e, MD 2	21201				
S	tate	31. Date filed (Month, Day Year)	32.	Registrar's	ignature	Kel								
Regis	trar	JUN 23 2010	Lengue	V p.	Tage with						_			

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		•	for State Registrar	State of IVI	aryland / Depa <i>Cer</i>	tificate of		ivientai Hy	ygiene Reg. No.	2010	19656
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-	Medic Examin		DORA 4a. Facility Name (if not institution,	give street and number)		4b. City, Town, c	or Location of Death	JUNE	18 4c. (	2010 County of Death	10:30 P <sup>M</sup>
-	ZXGTIIII		7111 PARK HEIG			BALTIN	MORE				V/A
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	show dat	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	cation				1	0d. Inside City Limits
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	eath w	Funeral	7111 PARK HEIG	12. Was Decedent I	Ever in U.S. 13. V	21215 Vas Decedent of F	lispanic Origin? (S	pecify Yes or No	)- 1	4. Race - Americ	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? ed 1  Yes 2  If Yes, Give Year or Dates.	No 1	Yes 2 No	an, Mexican, Puert  Specify:	o Rican, etc.)	s	Black, White, 6	
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Maryland	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, La JACOB	ast)	GUTTER	SON	18. Mother's Nar	me (First, Middle	e, Maiden S	urname) NEEI	ni F
ary	should be file n and Mental H is marked o raumatic eve	32	19a. Informant's Name/Relationsh	ip (Type, Print)			and Number or Ru	ral Route Numb	er, City or 7		
	and 2 s Health em 27 ther tra		SHERYL GITOMER		<del></del>	HORNERS	LANE, BA	LTIMORE		21205	
nore	0 <del>-</del> -		20a. Method of Disposition  1    Burial 2 □ Cremation		20b. Place of Disposicements of ANSHE	FMY NYAH <sup>r pla</sup>	ce)	Date		cation – City or To ALTIMORE	
altimore,	permit. Page Department Important: I any injury o	- 5	4 ☐ Donation 5 ☐ Other (S)  21. Signa (re : Funeral Service Li			M CFMFTF  Name and Addre		21/2010 OL LEVI	-	& BROS.,	•
a	B B E E	)9	100	the			TERSTOWN	ROAD,	PIKES'	VILLE, M	D 21208
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Box 68760	ath certificate be executed attending physician and for use as the burial-transit	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnan			2	3d. Date of delive	ery
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Vita	ysicia is certi directo	To Be	examiner? 1  Yes 2 No	Hospital:	ent 2 ER/Outpatien	Oth	ner:		sidence 6 l	Other (Specify)	
J of	ling Ph ). After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending		y, Year) 28b. Time of injury	28c. Injur wor	k?	28d. Describe	how injury	occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 28e. Place of Inju	ury - At home, farm, stre		Yes 2 No			Number or Rural	Route Number,
Ο̈́	pital or ours aft ral Dir		00 0 17	building, etc					own, State)		
	n 24 hc	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination and/or invest	igation, in my opini	ion, death occurred	at the time, date	and place,	and due to the cau	ise(s) and manner stated
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			K	ichand a Berg, w	<i>y</i>	1 20	020604		ا (م	9/10	

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DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Scr. 40; Svitz 450; 10755 Fall Raad; Lutherallz, Ind 21093

32. Registrar's Signature

31. Date filed (Month, Day, Year)
JUN 2 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Beg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUME 2<sup>2</sup>2<sup>y</sup> 2010 7:25 Ам Thomas Silhan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist . Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours June II 1**X** M 2 □ F 212-34-2061 75 °1′935 Marviand Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mary land Baltimore Parkton 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21120 U.S.A. Funeral 2928 Kidds Schoolhouse Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X☐ No White Specify 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatin once. 2 Rudolph Silhan, Sr. Mary Fuka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2930 Kidds Schoolhouse Rd. Parkton, Maryland 21120 Vincent Silhan/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gardens of Faith Cemetery 6/26/2010 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility RUCK TOWSON Funeral Home, Inc. 21. Signature of Funeral Service Lice 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Records, P.O. Box 68760 attending pl for use as t IF FEMALE: esn. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 Yes 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 **N**0 1 🗌 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ature and title of certific 29b. Sia 29d. Date signed (Month, Day, Year) une 22, 2010 cause of death (Item 23a) (Type, Print) CHARLES ST BALLINGKE, MD 21204 13 WOUF

DHMH 17 Rev 7/2009

State Registrar 32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Smoth Month 06 11:00 A M Day 20 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death Hillenwood Himore Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth **X** M 2 □ F Months Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Funeral Director 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Hillenwood Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) opday (0-12) College (1-4 or 5+) laintenance Be 17. Father's Name (First, Middle, Last) 18. Moth Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a confequence of): Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to as a consequence of): 5/9/2010 attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Obstructive Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Month Day 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hothma Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital Other: 2 🔀 No |은 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 🛭 Naturai injury 5 Pending 2 Accident
3 Suicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 49 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 3:40pSchack Lawrence 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Germany **Funeral** 1 🖾 M 2 🗆 F Hours April 3, 1929 Months 81 Director 029-22-2805 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 No Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6103 Buckingham "natural", or items 23 edical Examiner must 21210 Manor United Drive States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 NKorea Black, White, etc. 1 Never Married 2 X Married à Baltimore, Maryland 21215-0036 1 🗆 Yes 2 ื No If Yes, Give 1949–1951 Year or Date 1949–1951 White 3 Widowed 4 Divorced Completed Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natur lury or other traumatic event, the Medical lury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Architect Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Erica Schack Sormane Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6103 Buckingham <u>Manor Drive.</u> Donna Schack, Wife Baltimore, Maryland 21210 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 6/18/2010 Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signature of Funeral Service License Aman a Heaston 299 Frederick Road, <u>Baltimore, Maryla</u>nd 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Complications of intraductal papillary mucinous Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Ducito (or as a consequence oi): Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transi and Due to (or as a consequence of) ed by the attending physician detached for use as the buria P,O, Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, Vascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe te 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending work 1 Tes 2 No Investigation 6 Could not be s after death 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Acertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)
JUN 2 3 2010

Grant

Towson, MD

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ဂ္ဂိ <del>ါ</del>	e atte	sicia	in the past 12 months? 1  Yes 2 No	4 Pregnant a			Other (sp						Month	Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANTHONY 2 Day SHIELDS 180C 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2704 KIRKWOOD DR HYATTSVILLE PRINCE GEORGE'S 7. Age (In yrs. last birthday) 55 <sub>Yrs</sub> If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 579-76-1.909 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**※** M 2 □ F Months Days Hours Min (Month, Day, Year Director MAY 1955 WASHINGTON. 20 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD PRINCE GEORGE'S HYATTSVILLE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2704 KIRKWOOD UNITED STATES hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 

XYes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 72 and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONTRACTOR COVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN SHIELDS permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic BARBARA SHIELDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLIE SHIELDS / WIFE 4201 SKYLIVE DR. SUITLAND, MD 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 Dpnation 5 Other (Specify) MD VETERAN CEMETERY : 6/15/10 CHELTENHAM, MARYLAND Funeral Service L 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., . Part 1. Enter the disease, of shock, or heart failure. List mplications that caused the death. Do not one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final +17erioso Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2010

State Registrar 30. Name and address of person who cou

pleted cause of death (Item 23a) (Type, Print)

32. Regis

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Month Physician/ MARGARET Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** N/AGlen Nursing & Rehab Center Balt<u>imore</u> 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month Day, Months Hours Min. New Jersev 71 Director 35-30-0624 1939 Feb. Usual Residence of Decedent shov 10b. Count 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3439 E. Lombard Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 າer than "natural", ເ , the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced **Black** Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 721 (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even ပ John Allen Margaret Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Tuck, Daughter 401 N. East Avenue, Baltimore, Maryland\_21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗌 Burial 2 🛛 Cremation 3 🗆 Removal from State 6/22/2010 Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MSCULAR Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) <sup>^</sup>Examiner equantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) MELLITUS physician and the burial-transit that initiated events Due to (or as-a consequence of) resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death signed by the all be detached f 1 Yes 2 9 Unknown 2 🗌 No P.O. Part II. Other significant penditions contributing to de but not sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? After this certificate I 1 ☐ Yes 2 ☐ No Yes 25. Was ca referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Tyes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Ratural injury work? 5 Pending death. n 24 hours after death. e Funeral Director: A eleted filled in by the fu Accident

Suicide

Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) ny

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWKA (WTW W&NT) 4 M () 24

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 June 2010 Robert Gene Thelen 9:21p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Court Baltimore <u>Catonsville</u> 8. Date of Birth (Month, Day, Ye Year If Under 24 Hrs **Funeral** . Social Security Numbe 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Hours 1 **X** M 2 □ F Nebraska Director 508-26-4907 82 1927 Nov. Usual Residence of Decedent 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 414 Oak Court 12. Was Decedent Ever in U.S. Armed Forces? 1949 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 1955 Specify: White 3 Widowed 4 Divorced Completed Year or Dates intal Hygiene. Ked other than "natura c event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Enrolled Agent Tax Preparation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev August The len Maude Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Correine V. Beck, Wife <u>414 Oak Court, Catonsville, Maryland 21228</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 6/18/2010 e of Funeral Service Licensee Amanda Heaston 21. Signa 22. Name and Address of Facilit Cremation Society of Maryland, 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) year Medical Due to (or as a conse y ence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) signed by the attending physician and dedetached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **N**0 1 Yes 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 performed? Yes 2 K No 1 🗌 Yes 2 🗌 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 201

State Registrar 30. Name and address of person

filed (Month, Day

232010

who completed cause of death (Item 23a) (Type, Print

32.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Van Brackel 1020PM Loran Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death washington Arund saltimore Anne WNR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth De<sup>(Month</sup>, 28<sup>th</sup>, Year) 928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M **Funeral** 1 M 2 D F Min. 220-20-2375 81 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ŪSA 355 Gatewater Ct. Unit 202 21060 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ş 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Korea Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Purchasing Agent Chevron Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ S. Van Brackel Hilda R. Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Gatewater Ct., Unit 202, Glen Burnie, MD 21060 Dorothy E. Van Brackel (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory or other place) @ Loudon Park 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/10 Baltimore, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Lettler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 ☐ No sate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29c, License number 中 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) 301 1-05Pital Dr. Glen Burnis Glen Burnic, MD 20161 0V9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ June 20 ay 2010 ar Nam Thi Vo 4:39 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Westminster If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month Day, Aug 19, 5. Social Security Number Birthplace (State or Foreign Country)
 MD Funeral 7. Age (In vrs. last birthday) 1 □ M 2 🛣 F 81 <sup>Year)</sup>928 Director 219-06-0716 Aug Usual Residence of Decedent or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 United States 14524 Settlers Landing Way filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ₺ Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify Completed 3 Widowed 4 Divorced Specify: Vietnamese Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, tite Mag Elementary/Seconday (0-12) College (1-4 or 5+) 6th Homemaker her home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hue Van Vo Thuan Chung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (great-nephew) 14524 Settlers Landing Way Gaithersburg, MD 20878 Duc Lam 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 5/21/2010 Winfield, MD 22. Name and Address of Facility
Furrier—Queen Funeral Home and Crematory
11212 W. Old Liberty Rd. Winfield, MD 2178 Signature of Euperal Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform After this certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Detner (Spec within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

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DHMH 17 Rev 7/2009

Registrar

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Kaman B Kangus 84) Mallalm dum, Werminsta MD 21157

29c. License number  $\Delta - 00542(8)$  29d. Date signed (Month, Day, Year)  $\Delta - 00542(8)$  26 - 21-10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month <sup>Day</sup> 2010 Physician/ 1:49 P M June Cora Ε. Williams Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Funeral (Month, Day, North Carolina 1 □ M 2 🕅 F Months Days Hours Min. Yrs. 90 Director Jan. 223-48-2789 Usual Residence of Decedent 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'Is marked other than "natural", or items 93a or 90a. f about 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 XYes 2 No Washington D.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20019 U.S.A. 3520 Clay Place N.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) permit. Page 1 and 2 should be t Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Maggie Henderson Lewis Winston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3520 Clay Pl. N.E. #1 Washington, DC 20019 James Williams (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Rooseve Tematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/18/2010 Chesapeake, VA 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility
Metropolitan Funeral Service f Funeral Service Dicensee Berkley Ave. Norfolk P /t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final Pulmonary Edema Physician/ isease o condition resulting in death) Medical Due to (or as a consequence of) Examiner ongestive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Myocardia attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month signed by the atte Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. William Critenden, MD III. Varnum St. NE Wash. DC 20017 1160 DR. William 31. Date filed (Month, Day, Year, 32. Registra s Signature State Registrar

		1 - For State Registrar	State of Ma	-	epartment of the Certificate of		•	giene Reg. No.	10	19667
Physici		1. Decedent's Name (First, Mid		mlin	Willia	a m.a	2. Date of Dea Month	Day	Year	3. Time of Death
/Medic Examin		Laura A 4  4a. Facility Name (If not institut.		omlin		a IIIS or Location of Deat	h B	-	nty of Death	3'207"
Funeral Director		Future Care 5. Social Security Number 217-24-3254			nday) If Under 1 Year Months Days	timore   If Under 24 Hrs   Hours   Min.	8. Date of Birt (Month, Da	y, Year)	9. Birth	place (State or Foreign ntry) VA
pu w		Usual Residence of Decedent  10a. State 10b. Coun	tv	10c. City, Town	or Location				1.	I0d. Inside City Limits
Maryla f sho	ō	MD 165. Godin	NA		altimore					1 ZÄVes 2 □ No
r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
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r deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. [	Race - Ameria	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be notified at once.	þ	1 Never Married 2 Ma 3 Widowed 4 Divorce	arried 1 □Yes 2√□ No		1 □Yes 2 XXNo				cify: Bla	
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and 2 and 2 ealth n 27		Nathaniel W	illiams-Son		12 Dana S		Baltimo			
Pages 1 and the pages 1 and th		20a. Method of Disposition  1 □ XBurial 2 □ Cremation	n 3 □ Removal from State	20b. Place of cemetery	Disposition (Name of crematory or other pla	ce)	Date	20c. Location	on - City or To	own, State
Datullion Detrait. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other	(Specify)	King I	Memorial		5/2010	Mood]	lawn,	Md
permit. Page Department of Important: If any injury or		2. Signature of Funeral Service	e Licensee		March F	H West	D - 1 4 5		24.7	21215
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tificate be executed g physician and as the burial-transit	edical		d							
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	sician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2,☑No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d.	Date of deliv Month	ery Day Year
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Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one)  Certify  2 Medica	ring Physician: To the best of al Examiner: On the basis of e and manner state	xamination and	death occurred at the ti /or investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	I manner as see, and due t	stated. o the cause(s)
To the vithin To the somple	Me	29b. Signature and title of certifi	ier		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
		Naymend !	mile no		DA	7683		6/z	1/13	
		30. Name and address of perso	n who completed cause of dea	th (Item 23a) (T	ype, Print)				*	
			2835 Smith A	ic Sure	203 Sal,	mer M	212 0	09_		
Sta Registra		31. Date filed (Month, Day, Year	32. Registrar	Sign <i>a</i> ture	11.	,				
OHMH 17 Rev 1/20		<u>J</u> (	MED CHILL	by circ	203 Bai					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCIS TUNE 20th 2010 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENESIS PERRING PARKWAY CENTER BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 4/78th, 1928ar) Marvland 216-20-7713 Director 82 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🙀 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8027 Hillendale Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 K Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patrick Wallace Nellie O'Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8027 Hillendale Road Parkville, Maryland 21234 Mary Ann Wallace / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 6/24/2010 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundral Seprice Licensee à 1050 York Road Towson, Maryland 21204 au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CLOSTRIDIUM DIFFICILE COLITIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Day 2 No 1 L Yes 2 L 9 Unknown Atter this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown sex choles terolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗆 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 🔀 No 1 Inpatient 2 X ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Sarma Khawa 10058965 215+ JUNE 2010

Registrar

State

SAIMA

31. Date filed (Month, Day, Year)

MD

KANDALLSTOWN

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis rar's Signature

KHAWATA

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min 1 X M 2 - F Months Days Hours 408-02-6962 56 05-04-1954 Minnesota Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 Yes 2 XNo Mountville Lancaster 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 17554 USA 134 Rockford Square Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Desert 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Sy Yes 2 No Desent Year or Dates: Storm 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Pilot American Airlines 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Molly Hall Lee F. Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mountville, PA 17554 Rockford Square Teresa L. Webster - Wife 134 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Indiantown Gap National Cem. 06/25/2010 | Annville, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Sa 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SERSIS

**Physician** /Medical **Examiner**  1-

10a. State

PA

Director

Funeral

Completed by

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**Physician** /Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown and injury or other traumatic event, the Medical Examiner must be notified at once.

g physician and as the burial-transit use d by the at detached f within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

disease of condition	_ a			
resulting in death)	Due to or as a consequence of):			
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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2 - ER/Outpatient	Othor	Home 5 Residence	6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 \( \text{Yes} \) 2 \( \text{No} \) No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of injury - At home, farm, streed building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	Physician: To the best of my knowledge, death xaminer: On the basis of examination and/or invand manner stated.			
29b. Signature and title of certifier	MOMO	29c. License number	29d. [	Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

within 2 To the I

istrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Matthew

31. Date filed (Month, Day, Year)

layor,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 C. Wilcox 9:20a. June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 718 West McPhail Road Harford Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day March 17 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Pennsylvania Director 160-20-8068 1919 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Harford Bel Air Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 718 West McPhail Road 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces o. Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Yes Maryland 21215-0036 "natural", 3 ₺ Widowed 4 □ Divorced If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Telephone Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Blair Burkhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Thomas, Daughter 718 West McPhail Road, Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/22/2010 Baltimore, Maryland Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. <u> 299 Frederick Road, Baltimore, Maryland 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ +reprovedevier accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has after death.

Director: After this certificate I performed 1 🗌 Yes 2 🗎 No æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA pleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Zcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) w m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year)
JUN 2 3 2010 Vac Phail 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VIVIAN LORRAINE WILKERSON <sup>Day</sup> 2010 JUNE 20, 12:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY 5. Social Security Numbe if Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 31, 1936 g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Director 577-48-6741 Wash. 74 May Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. Count 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Md. Prince George's 1 X Yes 2 No Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6610 Greig Street 20743 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Š Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within iment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the N Elementary/Seconday (0-12) College (1-4 or 5+) 11th Domestic Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 Oscar Tolliver Marie Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Johnson / Sister 505 Pacer Drive Landover, Md. Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 6-24-10 Landover, Md. 22. Name and Address of Facility Capitol Mortuary, Inc. r / f Funeral Servic⊢ 🗘 c 425 Maryland Ave., NE Wash., DC complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li Approximate Interval Between Onset and Death Immediate Cause (Final small coll comer of the hims Physician/ NON Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an 124 hours after death.

• Funeral Director: After this certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? ဂ္ 1 Yes 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mukemil Abdeller, me

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

prodecto

32. Registrar's Signature

18992000

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 18, 20b-c, per FH g904 6/23/10 TT

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE Month ANTHONY S. Medical 2010 5:20 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Director Country) 725-12-5118 Yrs. 88 Usual Residence of Decedent show 10a. State 10b. County 72 hours after death with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified MD BALTIMORE COCKEYSVILLE 28a-1 1 Tyes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10325 MALCOLM CIRCLE, APT. D 21030 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò 1 Never Married 2 🕅 Married ģ Baltimore, Maryland 21215-0036 "natural". 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed Specify: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uld be filed within I Elementary/Seconday (0-12) College (1-4 or 5+) 8 <u>MAINTENANCE OPERATOR</u> marked other BEVERAGE Be 17. Father's Name (First, Middle, Last) 185 Ketheris Nami (Eirsi Stücklig Kaiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ZINOWSKI STEPHANIE <del>UNKNOWN</del> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH ZYNA / WIFE 10325 MALCOLM CIRCLE APT. D COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of MD) every 20a. Method of Disposition 20c. Location - City or Town, State Owings Mills, MD 1 M Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/2010 SERVICE CORP: TOWSON, MD <del>6/21/2010</del> 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final NEUMON Ph sician/ On et and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day ate has been signed by the page 2 should be detached Yes 2 No 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown CORONAMY ARTEMY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag performed? Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSFICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert JUNE 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOBER MAN, MO 670/ N CHAPIES ST, SMITE 4105 BALTIMOTE, MD 21204 DANIEUR 31. Date filed (Month, Day, Year) egistrar's Signature 32. State JUN 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 6:26AM 1500165 6 10 AR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name of not institution, give street and number) Examiner AVE 7. Age (in yrs. last birthday) If Under 1 Year / If Under 24 Hrs. 9. Birthplace (State Country) or Foreign 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year Days Hours Months 1 □ M 2 □ 1 - 28 - 885 Manglan 20 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is hydical Examination in and the notified at once. 1 Yes 2 No Director Marghael **L**€c 10g. Citizen of What Country? 10e. Street and Number 20772 USA5013 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic 12 tonem 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HALLA JAMES ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. e, Zip Code) 19a. Informant's Name/Relationship\_(Type. Print) MI) 20772 5013 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lense Name and Address of Facility nerue 20608 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final To thrive year Physician 1000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner per fension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner YROUS Ch Vous Low back for use as the burial-trans Due to (or as a consequence of): Box 68760, physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐No 5 Other (specify) o. been signed by the should be detached 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has N page performed? certificate I 2 DH0 1 ☐Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕍 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending spital or Attendin nours after death. neral Director: Af / filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptific D042049 2010 ppe Maulbor 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hair 6 CHAMPALOUX WID U 31. Date filed (Month, Day egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Annie Bernice Barbour <u>12:1</u>4 ₽м 2010 <u>June</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Month, Day, July 28 Country) Min Director 219-12-3234 86 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Leonardtown 1 🗌 Yes 2 🛚 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 22680 Cedar Lane Ct. Apt. 1330 20650 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Board of Education Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Carter, Sr. <u>Annie Ophelia Young</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Tyer / Niece Box 115, Bushwood, MD 20618 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens June 17, 2010 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician -ardina c Medical Due to (or as a consequence of) Examiner HUPOVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interest and inter Examiner Due to (or as a convequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year n signed by the ail Id be detached for Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death the Funeral Directory of filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tem Cherie

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			Registrar			Cert	ificate of	Deat	h		Reg. I	No.		
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Si Lur of Funeral Service Licens	@/h n		22.	Cemeto Name and Add		cility Mat	tinglev-G	Gardi	ner Fu	neral	Home, P.A.
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io	death death tor: /	tific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2	P ∐ No					
Division of Vital Record	or A after Direc in by	Certificate:	4  Homicide determined	28e. Place of Injury building, etc.	y - At nome, (Specify)	rarm, stree	t, tactory, offic	9		28f. Location ( City or To	(Street a wn, Sta	ind Numbe te)	r or Rural	Route Number,
Ω	spital rours neral filled	cal	29a. Certifier 1 Certifying Phys	ician: To the best of m	v knowledge	death or	cured at the tir	ne date s	nd place a	and due to the co	auco(c)	and manna	r ac ctater	4
	To the Hospital or Attending Physician: The law requires that the death c within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u.	Medical	Check 2 L Medical Exami	ner: On the basis of exa	amination and	or investig	ation in my on	nion, deat	h occurred :	at the time date	and place	re and due	to the cau	se(s) and manner stated
	To th Withir To th	2	29b. Signature and title of certifier				29c. Licer					ate signed		
			* Kron	- MP			P	425	97		6	9-7-	-10	
0			30. Name and address of person who o							1		•		
Spring			Jeffrey Chase Brown,			okout	Road, Le	onard	town, 1	MD 20650				
	Stat	e ar	31. Date filed (Month, Day, Year)	32. Registrar	's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Edward Stanley Burroughs 12:13 p.M Tune Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 XM 2 □ F Days Hours (Month, Day, Year) 11/28/1936 Director 217-34-1119 73 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Mechanics ville Maryland | 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 20659 United States 41920 Gibson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Benjamin H. Burroughs, Sr. Louise Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 1, Mechanicsville, MD 20659 Marie Burroughs/Wife P.O. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ali Faith Episcopal Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/18/2010 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Ventricular standstill secondary disease or condition Medical resulting in death) Examiner respiratory failure Sequentially list conditions, Examiner cause (Disease or iinjury that initiated events Due to for as a non-sequence of Physician: The law requires that the death certificate be executed eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 0068540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reinhert My 25000 Pthokeut Rd Sthames (topital MO 206.00 31. Date filed (Month, Day Year)

State Registrar

Edward

Burroughe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Josephine L. Blythe 6,2010 8:25 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 630 Rolling Dale Road Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 335-32-4444 1 □ M 2 😿 F Hours Country) 0471671919 91 PA Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Anne Arundel Sherwood Forest 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Edge Hill 21405 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Force 1 ☐ Yes 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: "natural", Specify: White Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Josephine Hettel Frank Lehman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Stevens 630 Rolling Dale Road Annapolis, MD 21401 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Cemetery 6/10/2010 Shippensburg, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Ave. Hardesty Funeral Home P.A. Annapolis,MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) (DRONCHO) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the s g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Formula after death.

Funeral Director: After this certificate has be Funeral director, page 2 s autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughters Residence Other: 1 🗌 Yes 2 🔀 No 잍 4 Nursing Home 5 Residence 6 X Other (Special Residence) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29c. License number 29b. Signature and title of 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 139 Old Solomons Island Rd. Anthony Caputo Annapolis,MD 21401 31. Date filed (Month, Day, Year) JUN 08 2010 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 8<sup>Day</sup> 1. Decedent's Name (First, Middle, Last) 2010 **Physician** 2:00 PM 6 Joyce Strickland Boyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Snow HIll Nursing Home Snow Hill Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 □ M 2 □ F 95 5/26/1915 MD 216-46-1563 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Snow Hill MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21863 USA 4442 Nassawango Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. Specify: Completed by white 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker d 2 should be filed w th and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie E. Jones Clarence W. Strickland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. DE 19958 Harborview Rd., Lewes, Dr. John Boyer / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/12/2010 Girdletree, MD Spring Hill Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signatur of Funeral Service Burbage Funeral Home 108 William St., Berlin, MD23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** e disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician ar s the burial-t Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifie June, 08, 2010 30. Name and address of person who completed cause of death (Item 239) (Type, Print) DH 10 Poco v 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

D

DHMH 17 Rev 1/2001

		State of Maryland /	Department of Health and	Mental Hygiene
		1 - State Registrar	Certificate of Death	Reg. No. 2010 9680
Physic	cian	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Day Year  3. Time of Death
/Med			56	Tune 16 2010 1526 M
Exam	iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dec	tent
Funera		Chester River Hospital Cev  5. Social Security Number 6. Sex N. Age (In yrs. last b.	rthday) If Under 1 Year If Under 24 Hi	's. 8. Date of Birth 9. Birthplace (State or Foreign
Directo		217-18-0757 <sup>™ M 2□ F</sup> 87	Yrs. Months Days Hours Mi	June 28 1922 Maryland
PL .		Usual Residence of Decedent		10d. Inside City Limits
arylaı shov	5		n or Location	1 to the state of
he M 28a-f	Director	MD Kent Gale	na 10f. Zip Code	10g. Citizen of What Country?
G Z IZ 13-UU30 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, Ite Medical Evaminar must be redified at				U.S.A.
ns 23	Funeral	195 Birchwood Lane  11. Marital Status 12. Was Decedent Ever in U.S.	21635  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	
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A I A I S-00-50 d within 72 hours aft /giene. er than "natural", or i, Ire-hedical Exami,	l by	3 Wildowed 4 Divorced Year or Dates: WW L L	1 ☐ Yes 2 🛣 No Specify:	Specify: White
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e d la la	To Be	Joseph Patrick Beatty	Mary (	Goldie Gehardt
Vially land	=	19a. Informant's Name/Relationship (Type. Print) 19		Rural Route Number, City or Town, State, Zip Code)
		Harry C. Beatty, Jr (son)	1031 Chester Rive	er Dr. Grasonville, MD 2163
of Heal		20a. Method of Disposition 20b. Place cemet	of Disposition (Name of ery, crematory or other place)	Date 20c. Location - City or Town, State
Pages ment of ant: If it ury or o		1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.	Dennis Cemetery	
Dalitinore, permit. Pages 1 ar Department of Hea Important: If item 3 any Injury or other	ig	21. Signature of Pune of Service League	22. Name and Address of Facility Galena Funeral	Home of Stephen L Schaech
a and a c	OI .	M00510	1118 West Cross	St. Galena, MD. 21635
		23a Part / Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as card	iac or respiratory arrest, Approximate Interval Between Onset and Death
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/Medica Examine	•	Due to (or as a consequence		ILURE YEARS
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cuted od ansit	Examine	causé. Enter Underlying Cause (Disease or injury I that initiated events C.		
e exercian ar		resulting in death) Last Due to (or as a consequence	of):	
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ertific ding p	Mec	IF FEMALE:		1
eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal deal	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery  Month Day Year
the de	ysic	1 Yes 2 No 9 Unknown	5 🗆 Other (specify)	
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quires n sign	d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ fiknown
Invision of Vital necolus, if or Attending Physician: The law requires that death.  Inirector: After this certificate has been signed in by the funeral director, page 2 should be continued.	Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
The lav	E			- autopsy prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
VICAL DE SICIAN: The Is certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?	26. Place of D	Death (Check only one)
al or Attending Physician: Ts after death. In Director: After this certificat ad in by the funeral director, pa	일	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Hopatient 2 ☐ ER/C		g Home 5 ☐ Residence 6 ☐ Other (Specify)
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pital or At burs after of eral Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, ractory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
poital ours ceral lilled	2	29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.
e Hospital of 24 hours are Funeral Diletely filled is	edical	(Check only one)  2 Medical Examiner: On the basis of examination a and manner stated.		ocurred at the time, date and place, and due to the cause(s)
<b>To the</b>   within 2 <b>To the</b>   complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		* KRaenum MD	D00664	-41 JUNE 17 2010
		30. Name and address of person who completed cause of death (item 23a		EACTON AND THE
			SHINGTON STREE	9 EASTON MD 21601
S Regis	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Barke	
negis	Hill	213 2 6 6 6	1773	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year MARGUERITE М MADELINE TUNE 31 D Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours Min. April 8 097-18-5915 Director 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 23a United States <u>5710 Trailview Court</u> items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö <u>a</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Retail Stores Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Geraldine Fitzgerald Arthur Kalb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Catail Court, Frederick, Maryland 21701 Kathleen McCullough/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State June 18, 2010 | 4 Donation 5 Other (Specify) Gate of Heaven Cemetery |Silver Spring, Maryland 21. Signature of Funeral Service Licenses Keeney and Bastord PA Funeral Home MO1473 Church Street. Frederick. Maryland 21701 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final COPD Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Yea 4 Pregnant Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?
Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🔀 No မှ 1 | înpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accider injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on

State Registrar 29b. Signatu

Praveen

31. Date filed (Month, Day, Year)

JUN 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bolarum

32. Registrar's Signature

DHMH 17 Rev 7/2009

2/

29c. License number

MDD 62223

196 Thomas Johnson DR #135

29d. Date signed (Month, Day, Year)

Frederick, MD 21702

6/18/10

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital Division

> State Registrar

H

31. Date filed (Month, Day, Year) JUN 17 2010

29b. Signature and title of certifier

(Check only one)

Lloyd G. Cox, II, M.D. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

29c. License number

D 33766

DHMH 17 Rev 1/2001 OCME 2006

TETTEH, LCDR, MC, USN, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889-5600 HASSAN A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

217604

29d. Date signed (Month, Day, Year)

(Check only one)

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

State

Registrar

20b Amend per FH 5/8/10 AACO. DOH		FoAMEND#20lo per 1	LLL	f Marylan	d / Depa	ndelible Ir artment of tificate of	Health			/giene	201	e.	C 2 5	
Physicia Medi Examir	cal	Tensister 6/11/2010 AACO HEALTH DEPT. CMH  1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Dolling  4a. Facility Name (if not institution, give street and Jumber)  Anne Arrundel Medical Center  Annapolis  Certificate of Death Month Day Dolling  4b. City, Town, or Location of Death Annapolis  Annapolis											of Death	
Funeral Director		5. Social Security Number 219–28–6704		7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Di Sept.	rth ay, Year)	9. [	Birthplace (State or Foreign Country)		
W	ector	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel		y, Town or Loc				sept.	29,	1928 <u> </u>	larýland 10d. Inside C 1 □ Ye	City Limits	
th with the Maryland ms 23a or 28a-f sho must be notified at	Funeral Director	10e. Street and Number 600 McKinsey I	Park Drive	Apt 30	)4	10f. Zip Code 21146	 5			10g. Ci	itizen of What	Country?		
rite iner	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Mar 3 🏋 Widowed 4 ☐ Divorced	Armed Ford	2 <b>X</b> No		Vas Decedent of If Yes, specify Cub	an, Mexica	n, Puerto I	cify Yes or No- Rican, etc.)	-	14. Race - Ar Black, Wh Specify:	merican Indian, nite, etc. White		
212 within giene. er tha	• Completed		nt's Education est grade completed) College (1-4	4 or 5+)	(Give I life. Di	lent's Usual Occu kind of work done O NOT use retired Memaker	during mos	t of workin	ng	16b. k	Kind of Busines	ss Industry		
Maryland 2 should be filed the and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, L Windsor Puro	•					er's Name tie 2	(First, Middle Zepp	, Maiden	Surname)			
Mary d 2 shoul saith and I n 27 is m		19a. Informant's Name/Relations William Doering				g Address (Street 4 Meadow					r Town, State, .			
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injuy or other traumatic even once.		20a. Method of Disposition 1 IXBurial 2 □ Cremation 4 □ Donation 5 □ Other (S		State 20b. P	lace of Dispo	sition (Name of Profita this core Cemeter		7 <u>-28</u> 8/6/20	at <b>-unk</b> 10 )10	1	ocation - City	or Town, State		
Balt permit Depart Import any inj		21. Signature of Funeral Service L	_icensee		13 4	Name and Addr arranco 95 Ritch	& Son	Š, P. Y,	A. Sev Sev	erna verna	Park	Funeral MD 2114	Home 16	
Pnysician/ ⊟ Medical Examiner	6 3	23a. Part 1. Ent the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	aused the death h line. or as a consequ	WYEST	r the mode of dyi				rrest,		Approxima Interval Bei Onset and	tween Death	
ecuted land and latransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	6. <u>W</u>	r as a consequence of the conseq	ence of):	PUASIA						SHEUN	es es	
9. ਜ਼ 6	ı— ı	resulting in death, East	d	. 40 4 00110040										
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. The law requires that the death certificate has been signed by the attending physician to the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buriance of the contraction of the province of the pro	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2		irth 2 🗌 Feta ant at time of d	I death 3	Ectopic pregnan	су				23d. Date of o	•	Year	
ds, P.O. quires that the sn signed by to	ed by Pł	Part II. Other significant condition	ns contributing to dea	ath but not resi	ulting in the u	nderlying cause g	iven in Part	I.	23e. Did t			to the cause of c		
Record The law rectate has bee	Complet								24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy ormed?	prior to death	autopsy findings a o completion of c ? 'es 2 (**)		
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of V ng Phy ter this neral d	te: To	27. Manner of Death	28a. Date o	npatient 2  f injury n, Day, Year)	28b. Time of injury	28c. Inju	4 ∐ No ryat		ne 5 ∐ Resi 8d. Describe l		Other (Spe y occurred	ecify)		
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	1 Natural 5 Pending   (Month, Day, Year)   injury   work?   1									Rural Route Numb	pe <i>r</i> ,		
e Hospit n 24 hour e Funera	Medical	(Check 2 Medical E	Physician: To the be- xaminer: On the basis Nurse Practioner: To	of examination	and/or invest	gation, in my opin	ion, death o	curred at t	he time, date a	and place	and due to the	e cause(s) and ma	ınner stated.	
To the within To the Comp		29b. Signature and title of certifier	Wase	(U)		29c. Licens		64			te signed (Mor			
CHO		30. Name and address of person	who completed dause	of death (Item	2βa) (Type P	37AJ	4D38	D	Ann	HOS	aw u	1401		
Stat Registra	G	31. Date filed <i>(Month, D</i> ay, Year)  JUN 0 8	3 2010 32. By	gistrar's Signati	ure d	ark								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :43AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/28/1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Director Yrs. 067-26-0030 Usual Residence of 28a-f shov 10a. State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MDCrofton Anne Arundel 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1485 Crofton Pkwy. 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1954-Black, White, etc þ 1 Never Married Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: White Completed 3 Widowed 4 Divorced 1974 Specify 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Officer/Pilot US Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward H. Dawson Dagmar Almgren permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Dawson 1485 Crofton Pkwy. Crofton, Md 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial AS Cremation 3 Removal from State Atlantic Crematory 6/8/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 7 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State: Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State

eleted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4. U i U For WCHD 6/9/10, E.T, State Registrar 23a, Part 1, line b,c, Amended item Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 18:45 M JOHN MARK DAVIS 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Nicmie PENINSULA ROGIONA L Medicac ceater SALISBULY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 XM 2 X Months Min. Hours Mary land Director 224-96-4277 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matical at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Worcester Pocomoke City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21851 1403 Linden Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 12 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Gunter Dixie Lawrence B. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1403 Linden Drive, Pocomoke City, MD 21851 Dixie Davis, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06 10 2010 Temperanceville, VA J.W. Taylor Cem. Signature of Funeral ervice Ja 22. Name and Address of Facility Holloway Funeral Home, PA Vine Street, Pocomoke City, MD 21851 107 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTOINTE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Coagulopathy Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated to page 2 should to Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? this certificate Yes Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5  $\square$  Pending within 24 hours are.

To the Funeral Director: A' 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, H005619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Camil ST. 285 31 Date filed (Month. State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Plea	ase Type or State o								All Copie Mental Hy		_	ible.	10000	
	•	State Registrar					C	ertifica	te of L	Death			Reg.	No.	i U	19688	
Physicia	n/	Decedent's Name										2. Date of D _Month	eath	Day	Year 10	3. Time of Death	
Medic	al	ANTONIO		IX DIBE		ETTO		45 016	. Tours or	Location	of Dooth	June	<u>り</u> ,	4c. County		3:15 AM	
) Examin	er	FREDERI	CK MEM	ORIAL HOS	PIT		ast hirthday	I	REDE	RICK		8 Date of B	CK place (State or Foreign				
Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)									931		York				
ow t	L	Usual Residence of Decedent  10a, State 10b, County					y, Town or	onation								10d, Inside City Limits	
arylan a-f sh fied a	ecto	10a. State  Maryland		reder								1 Yes 2 X No					
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status  1 □ Never Married 2 🛣 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 ☒️Yes 2 □ If Yes, Give Year or Dates.												Blac	e - Ameri k, White, <b>Whi</b>		
2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)					16a. Dec	edent's Us			ost of work	ina	16	ısiness Ir	s Industry		
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2 shouth and it is in the standard traum		19a. Informant's Name/Relationship (Type, Print)  Thelma DiBenedetto / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 5601—C Avonshire Pl. Frederick, MD 2170													Code)		
Healt Healt		20a. Method of Disp		,		20b. F	Place of Dis	position (Na	ame of		June		_	c. Location -		own, State	
Page on the original interpretation in the original interpreta		1 X Burial 2 4 ☐ Donation		3 Removal from Specify)	State	Me	emetery, co Resth Moria	ematory or aven I Gar	other place dens	:e)	June	2010	F	rederi	ck,	Maryland	
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Physician/ Medical		Immediate Cause (Final Onset and De													Interval Between Onset and Death		
Examiner	J.	Pneumonia											DAYS				
te be executed nysician and ne burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Chronic obstructive pulmonary disease years pulmonary disease. Year Due to (or as a consequence of):												years			
To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1													ate of delivery onth Day Year		
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Box 68760 P.0. Records, Hospital or Attending Physician: Division of Vital

Baltimore, Maryland 21215-0036

in 24 hours
o the Funeral Dicompleted filler Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier JUNE 07,2010 00065201 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) FREDERICK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State arks Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-04536 State of Maryland / Department of Health and Mental Hygiene Gary Wayne Day 2010 19690 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month 1320 hrs **Medical Examiner** June 15, 2010 Gary Wayne Day c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Rockville 11810 Parklawn Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Davs Hours Min Country) Maryland Director 1 X<sub>M</sub> 2 57 215-48-9247 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 X No or 28a-f show or items 23a or 28a-f sho must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. <u>Pennsylvania Lancaster</u> Lititz 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Ö USA 34 Royal Drive uneral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married Never Married 2 X No Yes ũ Divorced If Yes, Give Year Yes 2 X No specify: Specify: White marked other than "natural", e event, the Medical Examiner ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Cabinet Manufacturer 12 Sales Representative 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Murray Day Betty Jean Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Royal Drive, Lititz, Pennsylvania item 27 Cynthia Gail Nowell Day, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition Baltimore, crematory or other place) 6/21/2010 1 X Burial 2 Cremation 3 Removal from State Frederick, Maryland Resthaven Memorial Gardens Other Specify Donation 5 22. Name and Address of Facilit Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee 20872 26401 Ridge Road, Damascus, Maryland M-Berger Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Thrombosis, left anterior descending artery Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a,27,per ME G904 6/28/10 TT sician The law requires that the death certificate be Box 68760 attending physi for use as the bu 23d. Date of delivery IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? 1 1 Yes 2 No page Yes 2 No certificate 26. Place of Death (Check only one) director, 25. Was case referred to medical or Attending Physician: Be examiner? Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 this ٥ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: X Natural 1 Pending Yes 2 Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide the Hospital the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 16, 2010

State Registra

ORIĞINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Rogeraling

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Russell Edwards Gary June 2010 9:30 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death C**harlot**te Hall Veterans Home St. Mary's Charlotte Hall 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Hours Min Director 483-40-6876 73 06/29/1936 Towa Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's 1 Yes 2XX No Mechanicsville 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 27236 Bosse Dr. 20659 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Yes 2 [ If Yes, Give Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Electrician</u> Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vernon Russell Edwards Lydia Marie Wirtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Langley/Daughter 27236 Bosse Dr., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 06/08/2010 Charlotte Hall, MD 21. Signature of Funeral Service Lice 22. Name and Address of FacilityBrinsfield-Echols FuneralHome, PA 0195 Three Notch Rd., Charlotte Hall, MD20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, ASPIRATION PHEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DYSPHAGIA Sequentially list conditions, Examine cause. Enter Under or lining Cause (Disease or liniury signed by the attending physician and d be detached for use as the burial-transit LEWY DEMENTIA Hospital or Attending Physician: The law requires that the death certificate be executed BODY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Be Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 1 Norsing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one)

State Registrar 31. Date filed (Month, Day, Year)

EENA

RAO

29b. Signature and title of certific

KODALT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0067788

29d. Date signed (Month, Day, Year)

2010

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BARRY T. FOX, JR. 1028AM 2010 Und Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memonal Hospita Stor at Eastor a f Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 **X** M 2 □ F Months Country) 02715/1923 87 Director 218-12-1241 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director must be notified 28a-f 1 X Yes 2 ☐ No TALBOT **EASTON** MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 29922 DOVER ROAD 21601 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner 0 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER TRUCKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MINNIE EFFIE HUTCHISON BARRY T. FOX, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARJORIE FOX/ WIFE 29922 DOVER RD., EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State CORDOVA, MD FAIRVIEW CEMETERY 06/12/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 MOHN R MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final reymon Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a considuence of for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed isompleted filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? 1 Yes 2 🗌 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature 29d. Date signed (Month, Day, Year) June, 02, 2010 M. D 10065656 IVA on who completed cause of death (Item 23a) (Type, Print) Eg-Con, M0760, RS 6 31. Date filed (Month, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gilbert Farnest June 3. 2010 Fields 10:39 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1XX M 2 □ F Days Hours Min 248 34 6209 Clover S.C. **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2xxxxx Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygient.
Important: If item 27 is marked other than "natural", or items 23a myoriant: If item 27 is marked other than "natural", or items 23b any Injuy or other traumatic event, the Medical Examiner must b Funeral 9607 Small Drive 20735 United States 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Capitol Police Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည James H. Fields Elsie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Fields (Wife) 9607 Small Drive, Clinton, MD 20735 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Sept 10, 2010 Arlington, Virginia Signature of Funeral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria M01555 Ferry Road, Clinton, M 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATITY Ph\_sician/ HYPOGLYCEMIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** TYPE DIABETES WELLITUS scue tially lite of dition, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live Birth 2 ☐ Fetal dean 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by END KIDNEY DISEASE STAGE 1 Yes 2 No 3 Probably 4 Unknown Completed peen FIBRILL ATION ATRIAL 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 death? eral Director, After this certificate filled in by the funeral director, page 21 No 1 🗌 Yes ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 Tes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0064986 6/3/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clinton

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month Marie Elizabeth Farrell 2010 8:32 p. Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F New York 1071471924 Director 113-18-6460 85 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director MD St. Mary's Hollywood 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20636 25793 Whiskey Creek Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White 3 ★ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John J. Nolan Victoria M. Rebholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Kubinec 25793 Whiskey Creek Road, Hollywood, MD 20636 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols 06/09/2010 Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signature of Inneral Septice Consecution 
Ldward Brinsfield Mooo52 22. Name and Address of Facility Brinsfield Funeral Home, P.A 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o for as a consequence of Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to for as a consequence on death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialng physician as the burial-Physician/Medical attending properties of IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing s in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 🐼 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA the Hospital or Attending Physithia 24 hours after death.
The Funeral Director: After this mpleted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the comple 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, Maryland 20636 /Jarbqe/, J

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, D

Box 68760

Records,

of Vital

Division

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Da**2010** Year 2, 9:50 AM Frock Bobby Dale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Oct. 17, Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 **X**M 2 □ F Months Hours **Director** 69 212-38-8826 1940 Maryland Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 828 Dunbrooke Court 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. ğ 1 Never Married 2 X Married 1 Yes 2 X No Specify: If Yes, Give White Specify. 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving Elementary/Seconday (0-12) College (1-4 or 5+) and Printing 12 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ellis G. Frock Naomi V. Stitely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Frock / Wife 828 Dunbrooke Court, Frederick, MD 21701 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 6/7/2010 Stauffer Middletown, Maryland Reformed Cemetery Funeral Home, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Fort T. Enter the disease shock, or heart failure. complications that caused Approximate only one cause on each\_i set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in modulate cause. Enter Underlying Cause (Disease or iinjury Examine Don't a for To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cholesterolemia 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c, Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastination in any original death. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Grissom, MD 1475 Taney Ave. #204, Frederick, MD 21702

32. Registrar's Signature

29c. License number

D21944

29d. Date signed (Month, Day, Year)

10

10-04645 Vivian Fiorita Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Ivian Fiorita		1- For State Registrar	ate of Maryland	-	ificate of			Reg. No. 201	0 969				
Physici Viedical Exam		Decedent's Name (First, Midd	le,Last) Louise		Fiori	t.a	Date of De Month	eath Day Year	3. Time of Death 0654 hrs				
Trailed Exam	11101	4a. Facility Name (if not institution		)		b. City, Town, or Locatio	June 20, n of Death	4c. County of Do					
		Golden Living Center				Cumberland		Allegany					
Funeral Director		5. Social Security Number 215–34–4993	6. Sex 7. Ag	e (In yrs. Iasi	t birthday) Yrs	Months Days Hou	ırs Min.	9. (MM/DD/YYYY) 9. (Fo	Birthplace (State or reign Maryland Country)				
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locati	on			10d. Inside City Limits				
<b>*</b> . 1	o	MD A1	legany		Cumb	erland			1 XYes 2 No				
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co											
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	/ Funeral		arried 12. Was Decedent Armed Forces' 1 Yes 2 orced If Yes, Give Year		If Y	s Decedent of Hispanic O es, specify Cuban, Mexico Yes 2X No specif	an, Puerto Rican, etc.)	White, etc	nerican Indian, Black, c. White				
iours ai iatural	d by	15. Decedent's Education (Spe	or Dates: cify only highest grade cor	npleted) 1	6a. Deceden	's Usual Occupation (Giv	e kind of work done	16b. Kind of Busine					
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natura or other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) 12	College (1-4 or	5+)	-	omemaker		Hom	e				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle Robert	William		Pollo	ck M		saba J	ewell				
MD 2. Id 2 should lith and Man 27 is man attice	To	19a. Informant's Name/Relations R. Todd Fiorit			-	Address (Street and No Lincoln Roa							
e, N 1 and 2 Health item 2		20a. Method of Disposition				tion (Name of cemetery,	Date	20c. Location - City					
MOF Pages nent of ant: If		1 Burial 2 X Cremation 4 Donation 5 Other S		ate		d Crematory	06/22/201	Q Cumber	land, MD				
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		21. Signature of Funeral Seprice				ame and Address of Facil 4 Decatur S		•	1 Home, P.A. 21502				
Physician // // // // // // // // // // // // //		23a. Part-I. Enter the disease, or failure. List only one cause	on each line.				cardiac or respiratory a	rest, shock, or heart	Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Lorazepam  Due to (or as a cons		icatio	n			Death				
	Ŀ	Sequentially list conditions, if any, leading to immediate	b	acuana of):									
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uted d ansit	Exa	events resulting in death) Last Due to (or as a consequence of):  d.											
e exection and in all - tr	Medical	X UNPENDED AMENDED 23a,27,28a-f,per ME g905 7/29/10 TT											
Sox 68760, leath certificate be executed e attending physician and for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	ne of pregnar	ncy 2 Fet	al death 3 Ector	pic pregnancy	23d. Date of delive Month	very Day Year				
Box he death r the atter	Physician/	1 Yes 2 No 9 V Uni		time of deda	5 Oth	er (Specify)			· · · · · · · · · · · · · · · · · · ·				
ires that the signed by I be detache	و	Part II. Other significant condit	ions contributing to deatl	n but not resu	ulting in the u	nderlying cause given in F		tobacco use contribute es 2 No 3 P	to the cause of death? robably 4  Unknown				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi	ompleted							psy prior death	autopsy findings available to completion of cause of ? Yes 2 No				
tal Recition: The certificate	S	25. Was case referred to medica examiner?				-	h (Check only one)		100 2 70				
f Vit Physic er this c	To B	1 Yes 2 No 27. Manner of Death			R/Outpatient		Nursing Home 5		her: Scene				
Sion of Attending Pt death. Ector: After by the funeral	Certification:	1 Natural 5 Pending   Fd 6/20/10 Fd 0644 hrs 1 Yes 2 No   Subject ingested drugs											
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certifi	3 Suicide 6 Could not be determined Coperation (Specify) Car 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State). Golden Living Ctr. Cumberaind, MD											
thin 24   the Fu	Medical		miner: On the best of m										
8 7 8 7	<b>B</b>	29b. Signature and title of certifie	and manner stated.	/	(	29c. License numbe	er	29d. Date signed (#	Month, Day, Year)				
		ann	1h/	1		O.C.M.E.		June 21, 2010					
		<ol> <li>Name and address of person Zabiullah Ali, M.D.</li> </ol>	who completed cause of d Assistant Medical Ex			Street, Baltimore,	MD 21201						
Si Regis		31. Date filed (Month, Day, Year)	3 2010 32. Registra	r's Signature	B. 15	an Est							

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State		State of M	1arylan			nt of He <i>te of De</i>		nd Me	ental Hy	giene	•					
			Registrar  1. Decedent's Name (First	, Middle, Last)			Cer	unca	te or De	<del>-aui</del>		2. Date of De	Reg. No ath	20	10	3. Time	erof Death		
	Physicia Medic		Betty						Month June	nth Day Ye				9:00AM					
-	Examin		4a. Facility Name (if not ins		4b. Cit	, Town, or Lo	ocation of D	Death		4c. County of Death									
ممرر	,		St. Mary'				nardt				St. Mary's								
	Funeral Director		5. Social Security Number 407-44-6171	6. Sex	] M 2 🖾 F 🕴 7. A	ge (In yrs. I	ast birthday) 74 Yrs.	Months		If Under 24 Hours		B. Date of Birl (Month, Da arch 2	th y, Year)	936	Count		e or Foreign		
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	yland •f sho ed at	ctor		County		10c. Cit	y, Town or Lo			D	1				. 10		City Limits		
	e Mar r 28a	Dire	Maryland  10e. Street and Number	St. Ma	ry's	Lexington Park							40 0	'A'	100000	1 ☐ Yes 2 🖾 No			
	vith th	ıral	46464 Chap	man Dri	ve	101. 2	10f. Zip Code 20653					10g. Citizen of What Country? USA							
	eath v	<b>Funeral Director</b>	11. Marital Status		2. Was Decedent	Ever in U.S	S. 13. \	Vas Dec	edent of Hisp	anic Origin	? (Specif	fy Yes or No-		14. Race					
36	filed within 72 hours after death with the Maryland of brygene. Other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	by	1 Never Married 2		1 ☑ Yes 2 ☐ No			lf Yes, specify Cuban, Mexican, Puèrto Rica 1 □ Yes 2 🏿 No Specify:							Black, White, etc. ecify: <b>White</b>				
21215-0036	atural	Completed	3 Widowed 4 D	Decedent's Edu	Year or Dates.								16h k						
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	and 2 sh Health ar tem 27 is		Jerry Dan G			i		-				exingto	-						
ore,	of Heal of Heal fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cre		C4-4		Place of Dispo				Da	te	20c. L	ocation - C	ity or To	vn, State			
ij	permit. Page 1 Department of Important: If i any injury or		4 Donation 5		emovai from Stat	e	les Mem	-		s Jur	ne 7,	2010	Lec	nardto	wn, M	lary1a	ınd		
Baltimore,			21. Signature of Funeral S	ervice License	tardine	U	22					ingley-( ardtown			neral	Home	, P.A.		
			23a. Part . Enter the disc shock, or heart failu	ease, or compli	cations that cause cause on each lin	ed the deat	h. Do not ente	er the mo	de of dying,	such as car	rdiac or r	respiratory an	rest,			Approxir Interval I	Between		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a a	Mu	ltro	rgar	) F	Fail	ure	<u> </u>				2		nd Death		
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98	certifii nding use as	In/M	IF FEMALE: 23b. Was decedent pregn	ant 23	3c. If yes, outcome			7 = 4 = -1						23d. Date	of delive	ry			
Box 68	death ne atte ad for	Physician/M	in the past 12 months 1 \( \text{Yes} \) 2 \( \text{No} \)	s?	1 Live Birth 4 Pregnant 9 Unknown	at time of	death 3 L	Other (						Mont	h	Day	Year		
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ξ	hysic his ce Il direc	To E	1 Yes 2 No	H	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing							e 5 🗆 Resid	dence	6 Other	(Specify)				
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Division of Vital Records,	Attender deatl	Certificate:		Investigation Could not be	28e. Place of In	ijury - At ho	ome, farm, str	M eet, facto		es Z 🗆 INC		28f. Location (Street and Number or Rural Route Number,				ımber,			
Divi	alor/ s after al Dire		4 🗆 Homicide	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)												own, State)			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director: dether this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			cian: To the best on er: On the basis of												manner stated.		
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16	ratis		30. Name and address of C'HANDRA	person who co	mpleted cause of	death (Iten	n 23a) (Type, F	Print) _		1	200		141	1000					
*10	ime		CHANDRA	B. S	A JJA,	240	35 TH	TRE	E No	rch K	ΨĦ)	TICL		1) 2	663	6			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 9698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Dr. Adelina Gutierrez-Baldwin 8:15PM Medical Dune 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOS PITAL ALTI MOR 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 26,1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Days Hours Min. 67 Philippines **Director** Yrs 491-72-9908 1943 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 🗆 Yes 2 🏞 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 388 Broadleaf Court 21108 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Completed 3 XWidowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pediatr<u>ician</u> Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andres Gutierrez Fidela Santos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Erin Way #113 Reisterstown, MD 21136 Aira Bautista-O'Donnell/Niece 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 5,2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 21. Signature of Funeral Service Licensee rarranco & Sons, P.A. Severna Park Funeral Home Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Loter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Mehalata Ovarian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ しして正 5 RR B Z Division of Vital Records, P.O. Box in the past 12 menths?

1 Yes 2 No Day Pregnant at time of death Year signed by the at Id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? this certificate 1 Tes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ Other: 1 Tes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 - Pending work? 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2 only one) 29b. Signature and title of certifier Kohit Jain MD03/2010) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar RONI

31. Date filed (Month, Day, Year)

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JUN 082010

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32. Registrar's Signature

Ballemer MD-21229

			1 - For State Registrar	State of	f Marylar		artment of H			giene leg. Ño.	0	196	99		
			1. Decedent's Name (First, Midd	ile, Last)					2. Date of Dea Month	th Day	Yeer	3. Time	of Death		
	Physici /Medic		Thomas	H.		3eary			6	16	10	024	15 M		
	Examin		4a. Facility Name (If not institution	-			4b. City, Town, or		ith	4c. Count	•				
			Allegany Heal	th Nur. and	Rehab.	Ctr.	Cumbe			Alleg	yany				
	Funeral Director		5. Social Security Number 289-22-8800 Usual Residence of Decedent	6. Sex 1 → M 2 □ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		3, 1929	9. Birth	place (State ntry)	or Foreign		
	land ow		10a. State 10b. Count		10c. Ci	ty, Town or Lo	ocation					10d. Inside	City Limits		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, the Medical Evertine must be notified at an Once.	To	19a. Informant's Name/Relation	nship (Type, Print)	::c_	19b. Maili	ng Address (Street a		Rural Route Numbe	r, City or Town	, State, Zij	Code)	707		
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Ś	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by F	Part II. Other significant condit	tions contributing to de	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor			1		
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Division of	l or Attanc after death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
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	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 tertify (Check only 2 Medics	ring Physician: To the at Examiner: On the ba	asis of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	ce, and due to the courred at the time, o	ause(s) and materials	anner as : , and due :	stated. to the cause	o(s)		
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law requires that the death certificate be executed burial-trar physician the ed by the a signed b funeral director, this 9 Hospital or Attending Pi 24 hours after death. 9 Funeral Director; After ti After t 24 hours a

To the

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

within 72 hours after

d 2 should be filed within the and Mental Hygiene.
7 is marked other than "

permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra

**Physician** /Medical

3altimore, Maryland 21215-0036

Certification: To 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/10 005370 9 25 1h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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# 210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1State of Maryland / Department of Health and Mental Hygiene For 19a State Certificate of Death Registrar Amend#10e&19bperfuneralhomeo/10/10/cdohbb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Year Havenner James 20:55 M June 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 71 yrs. g. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day, Year) Jan 16, 1939 1 XXM 2 □ F Months Days 579 50 3108 Washington DC **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX 1 ☐ Yes 2 ☐ No Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Clinton MD Prince George 10e. Street and NumberDunnigan 10f. Zip Code 10g. Citizen of What Country? 20735 **Funeral** 6610 Durnigon Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Superfresh Dairy Head Be onould be file with and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Havenner Mildred Lanham 19a. In In Change Mame/Relationship (Type, Print) 19b. Mailing **Artifasty fleet in**d Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) 1 and 2 s of Health item 27 Jeanna Havenner 6610 Dunnigon Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 ō <u>=</u> injury or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) June 10, 2010 Suitland, Maryland Cedar Hill Cemetery 21. Signatur of uneral effice win 22. Name and Address of Facility Lee Funeral home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years <u>Chronic Obstructive Lung Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Lung Cancer Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 2 🗆 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Other: 1 Tes 2 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practions To only one the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) June 8, 2010 20562 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BBM Barry Levin, M.D. 10215 Fernwood Road, Bethesda, MD 20817 Ste 405 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cory Kiyosha Hamasaki 2010 1:15 P M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day, Hours 1 X M 2 □ F 63 Months Min 576-46-6358 1946 **Director** Hawaii Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park MD 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral USA items 23a 21146 113 Round Bay Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene.

Inducatorist, if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Asian If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Software 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jayne Koike Harold Hamasaki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
113 Round Bay Road Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Nancy Hoyt / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 08, 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Baltimore, MD Metro Crmatory, INC. 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failt lie. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Physician/ disease or condition resulting in death)  $\sqrt{|\chi|}$ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ending physician ause as the burial-Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗀 No Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work Division hours after death. 1 Tes 2 🗌 No Investigation filled in by the 2 Accident
3 Suicide
4 Homicide Accident Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and∕tite of certifier 6/5/2010 well, wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST() a VT F. Sel ON (CL. MA, D 90) Bestgate Rd. Annapolis, Md. 21401 M.D. 900 ONICK,

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mont)

08 2010

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JE WAYNE A. HUDSON 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TENINSULA CENTER ESICOMICO ediCAL SALISBUIL If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 X M 2 □ F Hours 74 11-23-1935 222-22-4413 DELAWARE Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h. County within 72 hours after death with the Maryland 10d. Inside City Limits Director DELAWARE SUSSEX FRANKFORD 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 19945 UNITED STATES 28 CLAYTON AVENUE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married Ď Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRIC COMPANY METER READER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ VIOLA HUDSON O. CLIFTON HUDSON permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 CLAYTON AVE., FRANKFORD, DELAWARE 19945 BARBARA K. HUDSON/ SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
CAREY S CEMETERY Date 20c. Location - City or Town, State 1 X Byrial 2 C 3 Removal from State 6-11-2010 FRANKFORD, DELAWARE 4 Donation 5 Done 21. Sio ature of Fu. MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE 19945 23a. Par 1. Enter the A ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Mericle arcinoma cell Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be | 26. Place of Death (Check only one) 2 No Hospital Other: ၉ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 KNatural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical 1. Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge. Shall occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 068222 06/07/ 10

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Registrar

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JUN 09

31. Date filed (Month, Day, Year)

100 E. CARROIT ST.

32. Registrar's Signature

SAUSburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month marun, Year 13.14 PM 00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel <u>Annapolis</u> Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth **Funeral** 1 ፟ M 2 □ F Months Hours Min. (Month, Day, Year) 74 Yrs Director 220-34-3262 October 5 1935 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4 chan any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Marv's 1 Tyes 2 X No Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24704 Sotterly Road 20636 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest McClellan Joy Mary Lena Gatton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Elizabeth Joy Wife 24704 Sotterly Road. P.O. Box 822. Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 15, 2010 Charles Memorial Gardens Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, MD 20650 Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Roma Sequentially list conditions if any, leading to firm rediate Examine at a consequence di If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? ပ 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 24 hours after death. 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1) o- Hossein, mo 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 eme ·Shahrzad Hosselm 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Sherilyn Louise Jackman 7:43 A M 2010 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1521 Kensington Dr. Hagerstown Washington County Social Security Number 8. Date of Birth (Month, Day, March 31 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Min. Year) 1960 Pennsylvania Hours **Director** 089-52-5982 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland | Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1521 Kensington Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lowell Beckham Jackman Donna Smith Jackman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale A. Jackman-brother 5354 Sequoia Farms Dr. Centreville, VA 20120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 6-9-2010 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Diabetes Securitally list our life as Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Fullyer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has t autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 5  $\square$  Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Hospital Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

5H-10

State Registrar

29b. Signature and title of certifier

Dr. William

31. Date filed (Month, Day

Jefferson

and address of person who completed cause of death (Item 23a) (Type, Print)

Kerns

22911

D38471

Blvd. Smithsburg, MD 21783

29d. Date signed (Month, Day, Year)

68760

Box (

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 Day Physician/ Month 2010 4 24 Ам KEYSER June Medical ELLIS 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick <u>Frederick Memorial Hospital</u> Social Security Number 6. Sex 1 X M 2 - F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** (Month, Day, ) January 29 Days Hours 214-28-2361 Director 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8561 Indian Springs Road 21702 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No by Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Driller</u> Well Drilling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Ira Keyser Lenora Harley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Keyser / Wife 8561 Indian Springs Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, June 4 Donation 5 Other (Specify) Lewistown Cemetery 2010 21. Signature of Juneral Service Licenses Keeney and Bastord PA Funeral Home, 106 East Church Street, Frederick, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a, Part 1. Enter the disease Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Cancel 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopuperformed 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' Accident 1 \sum Yes 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral D Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 3642 2010 Name and address of

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 010 Physician/ 10:45p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel 600 McKinsey Park Drive Apt. #306 8. Date of Birth
(Month, Day, Year)
4. 1922 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours Min Massachusetts 011-14-0476 88 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notiflied at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Severna Park 1 🗌 Yes 2 🔀 No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA Apt. #306 600 McKinsey Park Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1. Marital Status Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. White If Yes, Give Specify: Completed 3 Divorced 4 Divorced WW II Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer <u>Aerospace</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ellen Daley 2 Henry D. Lawton, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 McKinsey Park Drive #306 Severna Park, MD 21146 Maryanne Lee Lawton/Wife Baltimore, June Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate art failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) PAG Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical death certificate be P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Month Pregnant at time of death Other (specify) signed by the all 9 Unknown 9 Unknown Hospital or Attending Physician: The law 'equires that the 24 hours after death. Funeral Director: After this certificate has l-een signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2. No Records, 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0064379 30. Name and address of per o completed cause of death (Item 23a) (Type, Print estate Rd Sufe 300 31. Date filed (Month, Day, Year) **8 2010** 

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 13:08P M Mullins Carolyn Suzanne 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 06/20/1942 212-40-0907 67 Director Maryland Usual Residence of Decedent shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince Georges Aquasco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16611 St. Mary's Church Rd. 20608 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. 1 Never Married 2 Married <u>8</u> Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4XX Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaonee. Elementary/Seconday (0-12) College (1-4 or 5+) Management Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Hobert Knellinger Helen Lucille Howes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16710 St.Mary's Church Rd., Aquasco, MD 20608 Linda Miller/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem.06/07/2010Charlotte Hall, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Brinsfield-Echols FuneralHome, P.A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Interstitial Pulmonary Fibrosis Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?
Yes 2X No page 2 this certificate Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred After iniury 1X Natural 5 Pending after death. Director: Aft 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hc

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 6 2010

State Registrar

10 pms

DHMH 17 Rev 7/2009

Takoma Park, MD

20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sung Lee,

31. Date filed (Month, Day, Year,

7901 Maple Ave.,

Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 10

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28tate of Maryland Odenary 267261 Hanks and Mental Hygiene 1 - For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month PM Physician/ trank Moore 6 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Genera Berlin Atlantic HOSPITO Worcester 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 65 Months Hours Min. DE **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director Castle DE Castle New 1 🗌 Yes 2 🗶 No 10e. Street and Number 10g. Citizen of What Country? ö permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 19720 Funeral 204 Garfield USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Moore Doris Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Garfield Avenue, New Castle Moore wite Chery Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Gracelawn Memorial Park 06/10/2010 New Castle, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Family Funeral Home Strand + Feeley Family Funeral Home 635 Churchmans Rd, Newark DE 21. Signature of Funeral Service Licenses 19702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final asphystatu Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner inflicted & trangula Sequentially list conditions. Examine Clinità for és é nossiquinnes eff if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1  $\square$  Yes Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA မ 28d. Describe how injury occurred hanged self. 28b. Time of **Found: 1.00**0 **P** •M 27. Manner of Death 28c. Injury at Certificate: 06/05/2010 After noore, 1 🔲 Natural 5 Pending 1 Yes 2 No 7/2010 ☐ Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 hed behind atravel m 28f. Location (Street and Number or Rural Boute Number, City or Town, State) 204 Garfield Ave. Selby ville, De New Castle, DE 4 Homicide determined atravel trulber Selby ville, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one the 29d. Date signed (Month, Day, Year) 29b. Signature an 2 1+5041) 6/7/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Drive, Berlin, MD 21811

State Registrar Smyder

31. Date filed (Month, Day, Year)

0.0

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ 11:00AM 2010 Nellie Caroline .Tune Newman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 24000 Page Lane Hollywood 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Country) 1 □ M 2 🖾 F 90 Yrs. Director November Tennessee 413-14-4929 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10b. County Director Hollywood 1 Yes 2 No St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 24000 Page Lane 20636 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15, Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Church Financial Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Johnson Jennie Harris Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23939 Page Lane, Hollywood, MD 20636 Jennie N. Page / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9 1 🖾 Burial 2 🗌 Cremation 3 🗎 Removal from State June 10, 2010 Leonardtown, Maryland Charles Memorial Gardens injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ arter aronany disease or condition resulting in death) Medical Due to (or as a consequen e of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ rejurgitation 1 Yes 2 No 3 Probably 4 Unknown Completed brillation 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 124 hours after death.

e Funeral Director: After this certificate has be betted filled in by the funeral director, page 2 s autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one

State Registrar 29b. Signa

30. Name

and address of person

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31. Date filed (Month, Day, Year)

attending

DHMH 17 Rev 7/2009

ed cause of death (Item 23a) (Type, Print

stringun

MD

00055682

Moakley St. Leonardtown

29d. Date signed (Month, Day, Year)

12010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2,45 A M Month Physician/ 2Att Crystal Medley Nick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner BWMC** Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 □ M 2X F Hours Jan 15 Year 944 Marvland 212-40-2247 66 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Anne Arundel Severn 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1714 Carriage Lamp Ct. 21144 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 💢 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 2 should be filed within 72 hours afte th and Mental Hygiene. 27 is marked other than "natural", Specify: 3X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 <u>Resident Supervisor</u> Woodland Job Corp Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Wallace Dorothy Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Terrance Evans(Son) 21113 1838 Goldsborough Lane Odenton, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veteran 1 X Burial 2 Cremation 3 Removal from State 6-10-10 Crownsville, Md. 4 Donation 5 Other (Specify) W Marne Reachescof Scills Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between US-6650 herosclevol Onset and Death Immediate Cause (Final 10 Physician/ disease or condition resulting in death) Medical Failure **Examiner** ena OUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h Was decedent prequant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day Pregnant at time of death isigned by the a 1 ☐ Yes 2 ≥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, has been sig Were autopsy findings available prior to completion of cause of 24a. Was an autonsy page death? rmed? 2 🔲 No 2 No this certificate 1 Yes Yes 25. Was case referred to edical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital 2 1 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) မ 1 🔲 Yeş 1 PInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated: 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 () DVI E, JROVGR Year) 31. Date filed (Month, Day, Registrar's Signature JUN 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Christin O'Brien 20 June 5:30 AM <sup>™</sup> Medical 4a. Facility Name (if not institution, give street and number)
Glade Valley Nursing & Rehabilitation 4b. City, Town, or Location of Death Examiner 4c. County of Death Center Walkersville Frederick 5. Social Security Number 8. Date of Birth Aug. 1, Year 922 Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 M 2 T Hours 217-18-8729 87 MaryTand Director Usual Residence of Decedent sa or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 No Walkersville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 23a Funeral 21793 105 Sandstone Drive, Unit 306 er than "natural", or items 23, the Medical Examiner must within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ò ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: specifWhite 3 Widowed 4 □ Divorced If Yes, Give Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Factory Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Catherine Unknown Fogle Winfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
20 Hammaker Street, Thurmont, MD 21788 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, Sharon Woerner, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State Clustered Spires Cem, June 24, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi e L. ensee Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ evononic disease or condition resulting in death) Medical Due to (or as a consequence of Examiner o Vein Thrombrois Sequentially list conditions, Examine if any heading to immedicause. Enter Underlying physician and s the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death certificate has been signed by the a irector, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lung Concor 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 46248 June 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin 5 (Rece, 100)

300 9th Street Frederick MO 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen B. Patterson  $J_{une}^{Month}$  6. 2010 1:35 Рм Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Country) Maryland 218-88-8318 Months 3/27/1964 46 Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County Anne Arundel within 72 hours after death with the Maryland Maryland 10c, City, Town or Location 10d. Inside City Limits Directo Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 180 Woods Drive 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 ☐xNo 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: American Indian Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than uld be filed within 7 I Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. Francis McCumber Patterson Ruth M. Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael B. Patterson - Brother 180 Woods Dr., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20a, Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/8/2010 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21403 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the bunal-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 □ Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 06, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 08201

2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item Registrar #4c, per phys., 6/9/10, BA Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 11:08 AM 2010 Beatrice Alzira Pyle S /Medical 4c. County of Death Worcester 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Berlin intai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5/21/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min. 1 ☐ M 2 🖾 F Months 88 PA 176-20-6245 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Modical Examinar must be notified at once. 1 □Yes \$T□No Director MD Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21811 51 Pintail Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 😿 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
Masters Deg Elementary/Secondary (0-12) P.E. Education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Pyle Audrey Dilks ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Julie Amenson (niece)</u> 15127 Ganley Rd. Boyds, MD 20841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 6/8/2010 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St. Berlin, MD 21811 RO, W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMIZA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 □ No Month Year 5 ☐ Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, No icate has been sign, page 2 should b 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Hospital or Attending Physician: The certificate 1 Yes 2 2 700 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ Pro 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After To the Hospin...
within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Em Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAG BURY 30 x 21802 BA 10 Atturan WANG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month E 2010 7:40 PM RICHARD ALAN PLEINIS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 1 X M 2 1 Hours Jan 17, 1941 503-38-8920 69 Minnesota Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be Florida 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Marion 0cala 1 ☐ Yes 2 🛚 No 10e. Street and Number 8442 S.W. 82nd Loop 10g. Citizen of What Country? U.S.A. 10f. Zip Code 34481 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 2 No X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates. Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineering (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Telecomm. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Pleinis Marie Kalmbach John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8442 S.W. 82nd Loop, Ocala, Florida 34481 Mrs. Susan Pleinis, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Jun 17, 2010 Smithsburg, Maryland 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donjation 5 Other (Specify) 21. Si natura of Funeral Service Licensel 2KeeneyAdesBasford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lymphoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No igned by the atte Pregnant at time of death Month Day Year g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 □ No 25. Was case referred to medical To Be the funeral director, 26. Place of Death (Check only one) 2 **N**o Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide Investigation after death Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifie D62180 MD

DHMH 17 Rev 7/2009

Registrar

Fau

31. Date filed (Month,

400 West

7th Street Frederich

ess of person who completed cause of death (Item 23a) (Type, Print)

Rizvimo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Naomi Maude Poole June 2010 2145 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

December 15, 1915 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 214-76-4946 1 ☐ M 2 🕱 F 94 Frederick Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 Willow Road, Apartment 453 21702 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H tem 27 Is marked otl Be Leonard G. Wachter Hattie Estelle Ray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Poole / Son 925 North Market Street, Frederick, Maryland 21701 Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery June 21, 2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Sept. 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home MO1433 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause we each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 📋 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I within 2. and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed

State Registrar

31. Date filed (Month, Day, Year)

JUN 23 2010

32.

DHMH 17 Rev 1/2001

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Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0338 AM Physician/ Year John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic Worceste, Hospit -Berlin benera 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Hours Min. 218-16-9735 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? Funeral 12629 Torquay Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Underground Supervisor Delmarva Power Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Elizabeth Clark John Elmer Quillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12629 Torquay Rd., Ocean City, MD 21842 Marian E. Quillen / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sunset Mem. Park 6/12/2010 Berlin, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that clause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. SRO Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of) executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown been signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 After this certificate 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

within 24 hours a

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BA 10+1

State

31. Date filed (Month, Day, Year) 2010

29b. Signature and fitle of certifier

29a Certifier

32 Registrar's Signatur

ares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anoia

Registrar

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0062 130

Healthway Dr.

21811

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10-04603	
David Carney Ryan	

Please Type or Print in Black Indelible lok. Fasure All Copies Are Legible.

David Carney R		1- For State Registrar		ate of Maryla		rtificate o		and Menta		Reg. No. 2	010	1972
Physicia Medical Exami		1. Decedent's Nam David Ca							2. Date of D Month June 18	Day Yea	or 1	ne of Death 54 hrs
				n, give street and nu	ımber)		4b. City, Town	, or Location of		4c. County of Death		
· ′ — —		309 Rustic					Perryville			Cecil	ala au i	
Funeral Director		5. Social Security 1 215-54-31		6. Sex	7. Age (In yrs.	last birthday) 59 Yrs	Months I		Min	7, 1950	7) 9. Birthplace Foreign Country)	
any		Usual Residence o	f Decedent 10b. County		Inc. City	, Town or Locat	ion		· · · · · · · · · · · · · · · · · · ·		10d II	nside City Limits
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ne Maryland or 28a-f show fied at once.	Director	10e. Street and Nu				,	10f. Zip Coo	le		10g. Citizen of WI	hat Country?	
the M 3a or 2	Dir	309 Rus	tic Ct.				2190	3		USA		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumante event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marri	ed 2 X M	arried Armed F					n? ( Specify Yes or I Puerto Rican, etc.)		- American Ind e, etc.	lian, Black,
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5-00 ed with tygiene other	Com	17. Father's Name	(First, Middle,			Meedan	icane	18.Mother's	Name (First, Middle			
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MD 21215-0036 and 2 should be filed within 7 and Mental Hygiene m 27 is marked other than aumatic event, the Medica	٢	19a. Informant's Na Maria Ry							er or Rural Route Nryville,			ode)
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Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Fu	neral Service	Licensee	1-	22. N R	ame and Add	ress of Facility rd Fune	ral Home.	P.A.	21011	
Physician	$\dashv$	23a. Part I. Enter th	e disease, or	complications that c	aused the death	. Do not enter t	ne mode of dy	ing, such as card	diac or respiratory a	arrest, shock, or he	art Appr	oximate Interval
Examiner		failure. List on Immediate Cause (	•		sclerot	ic card	iovascı	ular dis	sease		Betv	veen Onset and Death
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	je l	Sequentially list co if any, leading to in cause. Enter Under	mediate	Due to (or as a	consequence o	of):						
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5876 ertificat ding ph	- 2	23b, Was decedent past 12 months		e 1 Live b		2 Fe	tal death	3 Ectopic p	regnancy	Month	Day	Year
SOX (leath ce attender for use	ysici	1 Yes 2 1	lo 9 🔲 Unk	nown 9 Unkno	ant at time of de own	eath 5 Otl	ner (Specify)					
O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transi	y Phy	Part II. Other signi	ficant conditi	ons contributing to	death but not r	esulting in the u	nderlying caus	se given in Part	I. 23e. Did	tobacco use contri	_	
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of V ng Phy After th	$\vdash$	27. Manner of Deat	No	28a. Date (Month	of Injury Day,Year	28b. Time of li		njury at Work?		e how injury occurre		
sion Attendi death. ctor: /	gţi	1 X Natural 2 Accident	5 Pend	ing tigation	/			Yes 2 N		_		
The state of the s							28f. Location or Town,	(Street and Number State)	er or Rural Rout	te Number, City		
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one)		ysician: To the bes								(2)
To th within To th	Medical	one) 2 ✓ 29b. Signature and		nîner:On the basis o and manner si		nd/or investigat		ense number	rred at the time, dat	29d. Date signe		
		Signature and	()	on 1	4			C.M.E.		June 18, 20		, . our/
	-	30. Name and addr		who completed caus	•		<u> </u>			1		
		Jack Titus N		uty Chief Medic				Baltimore, MI	D 21201			_
St Regist	ate	31. Date filed (Mon	2 Year	32. Re	gistrar's Signatu	reparks	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Philomena V. Rizzi June 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Villa Rosa Nursing Home Mitchellville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛣 F Months Hours Director 577-18-0340 1912 New York Auq. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 3a or 28a-f sh t be notified a MD 1 Yes 2 No Prince George's North Forestville 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral "natural", or items 23 2718 Overdale Place 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 ₺ Widowed 4 □ Divorced Specify White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Domick Valenza unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard F. Rizzi / 4701 Locust Hill Ct., Bethesda, MD Page 1 and 2 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Metro Crematory 6/7/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the deat Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 00 Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 4 ☐ Pregnam 9 ☐ Unknown After this certificate has been signed by interal director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 Other: ျင 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending injury work?
1 Yes 2 No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined .n 24 hou.. the Funeral Dire edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 06-07-2010 726 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who JEdd 8116 Good LANKAM Richams Lock Rd JUN 0 8 201 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #18 per FH, RG FCHD 6/11/10
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year Rudinger Albert E Jr. June 9.04 PMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 1 X M 2 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Country) Virginia **Director** 229-28-9484 78 Ĩ 931 Sept. Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 1000 Evergreen Ave. 21701 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 e filed within 72 hours after ttal Hygiene. ed other than "natural", o 1 Yes 2 No 1 ☐ Yes 2 No Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Underwriter Superintendent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F þ Albert E. Rudinger, Sr. Emily Dunn Dunn permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Rudinger / Wife 1000 Evergreen Ave., Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 Durial 2 X Cremation 3 Demoval from State injury 4 Donation 5 Other (Specify) tauffer 6/8/2010 Crematory Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lies only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): physician and s the burial-transit To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attanding a hours. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 2 100 Pregnant at time of death Yes been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy 1 Yes 2 -No Yes 24 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ■ Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year,

JUN

32. Registrar's Signature

FARBLAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ June 1 Lisa Carol Ramsev 9:02 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11415 Lakeside Dr. Washington county Hagerstown If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Hours Mary Land 215-76-2257 51 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marked Examination 1 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11415 Lakeside Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Counselor 12 Cemetery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Edward Griffith Lula May Myers Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Ramsey-husband 11415 Lakeside Dr. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Smithsburg Crematory 6-10-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or finiury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical Be examiner? 2 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred s after death. I Director: After t 1 Natural 2 Accident injury 5 Pending Investigation 2 🗌 No filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріеть 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signat hid title of certifie 29d, Date signed (Month, Day, Year) 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 13H-6 32. Registrar's Signature Date filed (Month, Day, Year) State JUN 1 Registrar

## State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIA GONZALEZ SCHWARTZ JUNE 1, 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death 6649 PEACHBLOSSOM POINT ROAD EASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Months Days Hours 8/3/1917 224-72-4951 Director 92 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director MD TALBOT **EASTON** 10e. Street and Number Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be 10f, Zip Code 10g. Citizen of What Country? Funera! 6649 PEACHBLOSSOM POINT ROAD 21601 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Schuar þ 1 Never Married 2 Married Yes 2X No timore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 and Mental Hygie is marked other Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PEDRO NOLASCO GONZALEZ MERCEDES DIEZ 19a. Informant's Name/Relationship (Type, Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any in]ury or other trau PETER NOLASCO GONZALEZ SCHWARTZ 2811 O STREET N.W., WASHINGTON, DC 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State OXFORD CEMETERY 6/5/2010 OXFORD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lorins FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME. 23a and 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Immediate Cause (Final ARRHU Physician/ CARDIAC 1 Tama disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consultance of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 Ø No Pregnant at time of death 9 Unknown 9 Unknown P.O. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CANCEL Records, detrueny 24a. Was an autopsy page ostesarthote performed' Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending within 24 hours after death To the Funeral Director: A completed filled in by the fi 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0031867

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Idlewild Ave. Easton, MD

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

TALBOT

14. Race - American Indian,

WHITE

Approximate Interval Between Onset and Death

Black, White, etc.

SPAIN

2:30 P M

State Registrar

15 RS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2010 Charles Lindbergh Snead 6:57 AM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min (Month, Day, Year) Director 577-30-7178 83 Yrs. February 23. Virgini Usual Residence of Decedent or 28a-f show 10b. Count the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits St. Mary's Maryland Mechanicsville 1 Tes 2 No Ξ 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 23a 29745 Allen Road 20659 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 9 ģ 1 Never Married 2 X Married hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify and Mental Hygiene. If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Steam Engineer Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Thomas Snead Ruth 01gers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 29745 Allen Road, Mechanicsville, MD 20659 Rosemary L. Snead / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State any injury or June 7, 2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. lichaelot P.O. Box 270, Leonardtown, MD 20650 Jardener 23a. Part 1. Enter the diseas., or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit and death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? certificate 2 10 NO ☐ Yes 2 [ or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 II NO ျ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; A 1 Yes 2 No Investigation 6 Could not be the 1 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check To the I within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23590 POINTL HOSOMAL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ UNE Stuehler Doris Anne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HMMK TER BALTIMORE WATHINGTON MEDICAL LE CHEN MUZNIE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day ) 1 □ M 2 🛣 F Months Days Hours Min. 67 217-40-0231 1942 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director Severna Park MD Anne Arundel 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r Funeral 101 Linda Lane 21146 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker **Home** 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Maranet Doris Magruther William Bud Buell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Linda Lane Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Phillip Stuehler / Husband Date 04, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State June 2010 1 🔲 Burial 2 🔀 Cremation 3 🗔 Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HOUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5177714 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsv death? this certificate 2 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at ė 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury Matural Natural 5 Pending 24 hours a er decth. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, ģ determined building, etc. (Specify) City or Town, State) cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who co

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nole ed cause of death (Item 23a) (Type, Print)

Jul 6

Fleu Burnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Madeline Faye Smith 2010 4:00 Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Center Frederick Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Hours (Month, Day, Year) Country) Maryland 220-16-2771 83 Director June Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Frederick 1 XYes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 1421 Taney Ave., Apt. 528 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare <u>Nurses Aide</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Caroline Fox Thomas H. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richelle Putman / Daughter 8207 Morning Dew Lane, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/8/2010 Frederick, Maryland Stauffer Crematory Stauffer Funeral Home 21. Signature of Funeral Service Lie 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Sinter the disease, of complications that caused photeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line chronic Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Obstructive direas Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Lyes 2 9 Unknown page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check rifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and titl

State Registrar DHMH 17 Rev 7/2009 196

32. Registrar's Signature

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FREDERICE

me and address of person who completed cause of death (Item 23a) (Type, Print)

RAYEEN BOLARUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day NANCY LEE SWEENEY 2010 9.40 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year) ine 1, 1921 1 🗆 M 2 🕱 F Hours Director 577-22-3666 89 Pennsylvania June Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Monrovia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3933 Daisy Court 21770 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: Completed Year or Dates White d other than "natur 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) th and Mental F 27 is marked of traumatic ever pe Paul H. Griffith Pearl Genowine .. Page 1 and 2 should be treent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Sweeney/ Son 3933 Daisy Court, Monrovia, Maryland 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Potomac U. M. Church Cemetery Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland 21. Signature neral Service 22. Name and Address of Facility
Stauffer Funeral Homes P Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Immediate Cause (Final Onset and Death Physician/ cute disease or condition resulting in death) myocardo Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hear After this certificate Yes 2 No 1 🗌 Yes 2 🔽 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2No 1 Yes pritai:

Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of
injury
28c. မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or Hiden 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

s after death. I Director: After t completed filled in by within 24 hours a To the Funeral D Hospital To the I

DH-3 State

Accident Investigation	(Month, Day, Your)	M	1 ☐ Yes 2 ☐ No	:				
☐ Suicide 6 ☐ Could not be ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		ory, office		(Street and Number or Rural Route Number, own, State)			
Certifier (Check (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
Signature and title of certifier	7/ 1	29	gc. License number		29d. Date signed (Month, Day, Year)			
have 6	ahmos	MD I	000632	33	6-10-10			

MD

21742

hard ahmos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

580c Northern Ave Hagerstown Shahid Mahmood

31. Date filed (Month gistrar's Signature

Registrar

4

29b.

Medical 29a.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Robert Shannon 2010 Mar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Regiona Prince Laurel Hospita George's Laure If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9/10/1933 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months NOM 2□ F Yrs 578-42-1353 75 WestVirginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercises. 10c. City, Town or Location 10d. Inside City Limits Director 1√Yes 2 No Prince George's MD Temple Hills 10f. Zip Code 10g. Citizen of What Country? 4502 Weldon Drive 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Shannon Lucy Starfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Shannon/ Daughter 4502 Weldon Dr. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/12/2010 Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licens 2294 Old Washington RD Waldorf, MD20601 23a. Path. Enter the disese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart free. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Aspiration Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner I or Attending Physician: The law requires that the death certificate be execut after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Pulmonary perform Chronic Obstructive 2 X No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \Backsquare \) Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nega

Hega Ali, MD

Ali Gosi MD

30. Name and address Terson who completed cause of death (Item 23a) (Type, Print)

Laurel Regional Hospital

D69430

29d. Date signed (Month, Day, Year)

7300 Van Dusen Road

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMPSON Month. LANCHE 2010 935 M 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1970 Cambridge Dr. Crofton Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. Country) 017-32-6349 1277/1940 Director 69 MA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c, City, Town or Location 10d, Inside City Limits Director Anne Arundel Crofton 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1970 Cambridge DR. 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes Give 1 ☐ Yes 2x X No Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin Stannard UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Thompson Spouse 1970 Cambridge Dr. Crofton, MD 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 6/8/2010 Glen Burnie, MD 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus y n each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER'S TYPE DEMENTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: At Accident Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) EXENSE HAHWAY

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32. Fegistrar's Signature

8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Juanita 2010 Elizabeth Wrenn June 8:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6737 Amherst Road Bryans Road Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 □ Months Min. Sep (Month, Day, Year) ember 20,1936 Days Country) Virginia 227-44-6334 **Director** 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6737 Amherst Road 20616 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Year or Dates White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Branch Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Powell, Sr. Mariam Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Wrenn, Jr./Son 7477 Robin Road, La Plata, MD 20646 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 6/10/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature Fur eral Service Ligense M01458 <sup>2</sup>ARTHAR͙ECHÓTS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List ofly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Examir physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, to **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) uneral Director. After the dilled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 \sum Yes 2 🗌 No Investigation Could not be 2 Accident
3 Suicide
4 Homicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 7, 2010

State

Registrar

DHMH 17 Rev 7/2009

P.O. Box 2729, La Plata, MD

20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, M.D.

JUN 07

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Skone Anne 2010 12:00PM Weaver June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9005 Mitchell Road La Plata Charles Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F (Month, Day, Months Days Hours Min. Gountry) Mary1and Director 217-28-4547 80 May Usual Residence of Decedent should be filed within 72 mouts and and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 9005 Mitchell Road 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decess... Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Educator Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harold T.J. Skone Mildred Steffens other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Margaret Steffens/Cousin P.O. Box 1462, La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Brinsfield-Echols 6/4/2010 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22 AREHART-ECHOLS FUNERAL HOME, P.A. av 20646 Mary's 211 St. Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence requires that the death certificate be executed the attending physician and ned for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law has performed? Yes 2 No 2 🗆 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 🗓 No 1 Yes ျပ 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral. 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 MIUL

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 9:09 PM Edith Wood Mary 2010 June 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🏻 F Months Hours 217-28-1163 **Director** 78 May 30, Maryland 1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Mudical Examinar must be notified at Director Maryland St. Mary's 1 X Yes 2 □ No Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22810 Dorsey Street, Apt. 209 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify Specify: White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Own Home <u>Homemaker</u> permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygit Important: if Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Wilson Russell Mary Magdeline Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Wood / Son 24365 Old Hollywood Road, Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Aloysius Cemetery Leonardtown, Maryland June 12, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Fuenral Home, P.A. nchael 7 P.O. Box 270, Leonardtown, MD 20650 Q fardines 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CUTE **Physician** DAY( disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STENOSIS CAROTIN Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-tran and Due to (or as a consequence of) the attending physician hed for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗌 Ectopic pregnancy Year 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? · DIARETES WELLITUS 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should need HIPERTENSON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? ta or Attending Physician: The safter death.
al Director After this certificate 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28b. Time of in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a within 24 hours s To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 eme RADINDER S. GILL MD ST WARYS LEGNARD JUNN 20650 HOPPIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 10 2010 Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\operatorname{June}^{\scriptscriptstyle\mathsf{Month}}$ Alice Estelle Woodburn 20 Par 12:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Mary's Leonardtown Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🔀 F Months Days Hours Min (Month, Day, Year) 213-74-8415 Director 105 September 5 1904 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖳 No MD St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23217 Bayside Road 20650 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Manley Higgs Florine Lucretia Bowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis B Woodburn/ Son 5304 Summer Plains Drive Mechanicsville, Va 23116 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State njury or St. Aloysius Cemetery Leonardtown, Maryland June 11, 2010 4 ☐ Donation 5 ☐ Other (Specify) Sign turn of Funeral Service loceris 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 9 41590 Fenwick Street Leonardtown, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition erosce Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, It any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Divi to for as a nonsequence on or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year signed by the a Id be detached for Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gretifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature nd title of certifie 29d. Date signed (Month. Day, Year) zur 6 pms 30. Name and address of person who commeted cause of death (Item 23a) (Type, Print) William D. Boyd, II 25365 Point Lookout Road, Leonardtown, MD 20650 31. Date filed (Month, Day, Year) State JUN 10 2010 Registrar

Physician
/Medical
Examiner

**Funeral Director** 

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widcal Evan, Included at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

cate has been signed by the a page 2 should be detached to

P.O. Box 68760.

Division of Vital Records.

Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certific completely filled in by the funeral director, death. within 24 hours a

2. Date of Death 3. Time of Death  $\mathtt{J}^{ ext{Month}}_{ ext{une}}$ 20 T O 1843 М 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Apr 10 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F Pennsylvania 66 227-56-0493 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Anne Arundel Davidsonville 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21035 3537 Riva Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Ses 2 No If Yes, Give Year or Dates 967-71 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Waddy Sr Faye Cook ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Waddy(Wife) Davidsonville, Md. 21035 3537 Riva Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 6-11-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Regulación Secilis Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Reese MOO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liner or userlying Cause (Disease or injury that in list and or the cause) Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unimown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ly atient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TSertifying Physician: To the fest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the fasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ner stated. 29b. Signature ar 06/03/2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SNICH Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	= For Amended #19	State o	f Maryland RG FCH	d / Depa D 6/10 Cen	rtment	of Hea	alth and M a <i>th</i>	lental Hy	giene Reg. No	010	9737	
			Decedent's Name (First, Middle			2. Date of Dear			ath 3. Time of Death					
	Physicia		William Wilke:	reon						Month June	Day 5	Year 2010	804 P M	
	Medic Examin		4a. Facility Name (if not institution,		ber)		4b. City, Town, or Location of Death			odije	4c. County of Death			
	LAGITHI	51	Montgomery Ho			,		kvi11			Mc	ntgome	rv	
-	Funeral		5. Social Security Number		7. Age (In yrs. Ia		If Under 1	Year If	Under 24 Hrs.	8. Date of Bir	th	g. Birtl	nplace (State or Foreign	
	Director		230-80-4265	1 ♣ M 2 □ F	55	Yrs.	Months [	Days H	ours Min.	10-31-	-1954_	Vi	rginia	
	3		Usual Residence of Decedent											
	sho dat	ţ	10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Limits	
	Mary 28a-1 otifie	<u>s</u> [	Maryland Mont	gomery		Gai	thersb						1 Yes 2 K No	
	a or be n	<u>_</u>	10e. Street and Number				10f. Zip Ci	ode			10g. Citize	Citizen of What Country?		
	s 23	Funeral Director	9816 Log Hous	e Court				2088	2		Uni	ted St	ates	
	death item item		11. Marital Status	Armed For	dent Ever in U.S rces?				nic Origin? (Spe lexican, Puerto l		14	. Race - Amer Black, White		
9	", or amir	þ	1 Never Married 2 Mar	15 V O:-	2 🔀 No e	1	☐ Yes 2	No S	pecify:		Sc		hite	
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7	72 hc n "na ledic	힐	(Specify only highe	st grade completed)		(Give k	ent's Usual C ind of work o NOT use re	done durin	ng most of worki	ng	16b. Kind of Business Industry			
2	ithin ene. • thai	등	Elementary/Seconday (0-12)	College (1	-4 or 5+)		e Pres		t			Constr	uction	
Maryland 21215-0036	ed w Hygir other	Be	17. Father's Name (First, Middle, L	ast)		VIC	C IIC	-	. Mother's Name	e (First, Middle,	Maiden Su	rname)		
a	be fill ental ked c c eve	힏	William Clyde	,	n				Marian	Louise	Mich	ae1		
₹	ould Mar mar					19b. Mailin	a Address (S	Street and	Number or Rura	l Route Numbe	er, City or To	wn, State, Zip	Code)	
Š	2 sh Ith ar 27 is 1 trau		19a. Informant's Name/Relations Will Marian L. Wilk	cerson <del>cersin</del> / M	other								nia 23228	
ē,	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "Hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	01011 / 11	20b. P	lace of Dispos	sition (Name	of		Date		tion - City or		
			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Giate	emetery, cren				e 11, 010	Hono	<sub>170</sub> 11	Virginia	
Baltimore,	artme ortar injur		21. Signature of Euneral Service I		IADD	omatta:	. Name and						es, P.A.	
Ba	permit. Page Department of Important: If any injury or once.		1090	tes					שני				land 21771	
			23a. Part 1. Enter the disease, or	complications that	aused the deat							,	Approximate	
			shock, or heart failure. List of Immediate Cause (Final	only one cause on ea	ich line.								Interval Between Onset and Death	
-	Physician/ Medical	- 0	disease or condition resulting in death)	a. Meta	stic Sq	uamous	Cell	Canc	er of T	onsils			3 years	
	Examiner		resulting in death)  Due to (or as a consequence of):											
	46	je	Sequentially list conditions,  Due to or as a consequence of):											
	nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury											
	xecur n and al-tra	EX	that initiated events resulting in death) Last	C. Due to	(or as a consequ	uence of):								
0	ate be executed ohysician and the burial-transit	dical		<b>L</b> a								6		
1,60	icate g phy is the	/led												
89	certif nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna Birth 2 D Feta		Ectopic pre	agnanov			23	d. Date of de	•	
ŏ	eath a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Preg	nant at time of o		Other (spec					Month	Day Year	
Э.	the d by the acher	hys	9 Unknown	9 🗌 Unki										
Division of Vital Records, P.O. Box	that ned k		Part II. Other significant condition	ons contributing to d	leath but not res	ulting in the u	nderlying ca	use given i	in Part I.				the cause of death?	
3,	uires in sig uld b	ed		_						1 🗆	Yes 2	No 3□P	robably 4 🖺 Unknown	
oro	v req	plet								24a. Was	an opsy	24b. Were au	topsy findings available completion of cause of	
ec Sec	he lay te hay age 2	Completed by		-						perf	ormed?	death?	s 2 🖾 No	
<u> </u>	an: TI tifficat tor, pr	Be C	25. Was case referred to medical					26. Place	of Death (Check		2 03 110			
Ĭ	ysicia s cer direct	To B	examiner? 1 ☐ Yes 2 🖾 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DOA	Other:	4 D Nursing Ho	ome 5 🗌 Res	idence 6	Other (Spec	eify)	
of	g Ph er thi neral		27. Manner of Death	28a. Date	of injury th, Day, Year)	28b. Time of injury	280	c. Injury at work?		28d. Describe				
n	ath. r: Aft	ica		gation	in, bay, roar,	,	М	1 🗆 Yes	3 2 □ No					
2	er de recto by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	28e. Place	of Injury - At ho	ome, farm, str	eet, factory,	office			(Street and I wn, State)	Number or Ru	ral Route Number,	
2	tal or rs aft		7	7		<u></u>	_							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 5 Medical	g Physician: To the ba	sis of examination	n and/or inves	tigation, in my	y opinion, o	death occurred a	t the time, date	and place, a	nd due to the	cause(s) and manner stated.	
	the Ihin 2, the F	Me	only one) 3 🗌 Certifyin	Nurse Practioner:	To the best of m	y knowledge,	death occurre	ed at the tin	ne, date and plac	ce, and due to t	he cause(s) 8	and manner as	stated.	
_	<b>5</b> with		29b. Signature and title of certifie		. 4	190		License nu				signed (Monti		
			John	uma				17	7123		61	6/10	)	
			30. Name and address of person		se of death (Item	n 23a) (Type, F	Print)	י גם	0001237411	a Mn	20855			
	13		Dr. Joseph Put 31. Date filed (Month, Day, Year)		001 Muno	turo			ZOCKATT1	LE, FID				
	Sta Registr		JUN	8 20 0	Answa Answa	- 10	frank	1						
	-					No.	- 37						_	

## permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hyglene. Important: If iten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmitte event. In Maryland and injury or other transmitte event. Baltimore, Maryland 21215-0036

Fune Direc

Physici /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Tuneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

an	1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	tificate of L	Tairi	2. Date of Deat			3. Time of Death		
al	F	EDNA MARIE WA	ARRENFI			June	- /	J.Oar	6:10 A		
er	4a. Facility Name (If not institution, give stre Kline Hospice House	et and number)		4b. City, Town, or Mt. A	Location of Death  iry		,	4c. County of Death Frederick			
	5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. I	last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept • 2	, Year) 934	9. Birth Cou Mar	Birthplace (State or Foreign Country) Mary Land		
	Usual Residence of Decedent  10a, State 10b. County	10c. Cit	y, Town or Loc	cation					10d. Inside City Limit		
tor									1 √Yes 2 □ N		
Director	10e. Street and Number	1	0g. Citizen of V		ntry?						
ral	1421 Taney Avenue	Apt. 222		2170	2	U.	S.A.				
by Funeral	3 Widowed 4 □ Divorced	Was Decedent Ever in U.: Armed Forces? 1		Vas Decedent of H iYes, specify Cuba □Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	ican Indian, etc. ite		
Completed	15. Decedent's Educati (Specify only highest grade co	ion	i (Give	lent's Usual Occup kind of work done of OO NOT use retired	luring most of worki	ng	16b. Kind of Business/Industry				
omp	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	,		Own	Home			
BeC	17. Father's Name (First, Middle, Last)						Maiden Surname)				
To B	Charles Gilbert				May Kauf	man					
	19a. Informant's Name/Relationship (Type. Print)  Earl Warrenfeltz / Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 9908 New York Street, Tibsonton, FL 33										
	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Lo										
edical Examiner		Due to (or as a consequence of the consequence)	Do not enter uence of):		MARKET S	VIII TO THE REAL PROPERTY OF THE PARTY OF TH		MD	Approximate Interval Between Onset and Death		
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown								very Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
þ						24a. Was a	n 24h	Were aut			
þ						autops perfori	med2/	prior to c death?			
	25. Was case referred to medical	pital		To:	26. Place of Death	autops perfori 1 □ Yes n (Check only on	med? 2 No	prior to c death? 1 ☐ Yes	ompletion of cause o		
To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 Hos	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At h	28b. Time of Injury	28c. Injur Worl M 1 🗆	er: 4□ Nursing Ho y at ?? Yes 2□No	autops perfor  1 Yes  n (Check only on me 5 Reside 28d. Describe he	ence 6 octr	prior to c death? 1 □ Yes ner (Spec red	Sify)Hospice		
Certification: To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specif.	28b. Time of Injury ome, farm, stro	28c. Injur Worl M 1 □	er: 4□ Nursing Ho y at ?? Yes 2□No	autops perfor 1 Yes  (Check only on me 5 Residu 28d. Describe he 28f. Location (S City or Town	med2 2 No re) ence 6 Noth ow injury occur treet and Numl n, State)	prior to c death? 1 □ Yes  mer (Spec red	ompletion of cause of 2 □ No  sify) Hospice  ral Route Number,		
Certification: To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At ho	28b. Time of Injury	28c. Injury Worl M 1 == eet, factory, office n occurred at the til vestigation, in my c	er: 4 Nursing Ho y at ? Yes 2 No me, date and place, pinion, death occur	autops perfori 1  Yes  (Check only on me 5  Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, ced	med 2 2 No lee)  ence 6 Noth  treet and Numb  cause(s) and m  attention and place,	prior to c death? 1 □ Yes  ner (Spec red  per or Ru  manner as and due	ompletion of cause of 2 □ No  2 □ No  Sify)Hospice  ral Route Number,  stated. to the cause(s)		
To Be Completed by	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specifican: To the best of my knorr. On the basis of examina and manner stated.	28b. Time of Injury  ome, farm, stru  owledge, death attion and/or in	28c. Injury Worl M 1 □ eet, factory, office n occurred at the til vestigation, in my of	er: 4 Nursing Ho y at Yes 2 No me, date and place, pinion, death occurre	autops perfor 1  Yes  n (Check only on me 5  Reside 28d. Describe he 28f. Location (S City or Town and due to the cored at the time, co	med2 2 2 No med2	prior to c death? 1 □ Yes  ner (Spec red  per or Ru  manner as and due	ompletion of cause of 2 □ No  2 □ No  Sify)Hospice  ral Route Number,  stated. to the cause(s)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:15 A M Frank Hammond Warfield 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington County Hospital Washington County Hagerstown 5. Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of L. (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Country) Mary Land 215-26-9037 Director March Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 X Yes 2 □ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 64 Sunbrook Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor Health Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Carr Warfield Thurmon Russell Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris C. Warfield-wife 64 Sunbrook Lane Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Welty Church Cemetery 6-10-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown. MD 21742 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) veatu Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine igned by the attending physician and be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed? certificate I Yes 2 No 2 No the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred 1 🖼 atural injury work? 5 Pending 2 🗌 No Accident Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State 24 hours a Funeral C Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DH4+1

State Registrar Date filed (Month, Day Year)

32. Registrar's Signature

A face

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norman Preston Young June 6, 2010 2:47 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 10111 Queen Elizabeth Drive Upper Marlboro Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Days Months Hours Min. (Month, Day, Year, Country) PA Director 170 28 9120 74 Nov Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10111 Queen Elizabeth Drive 20772 United States 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene. Firen 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 XXYes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify.White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Air Force Suppy Management Superintendent Be 18. Mother's Name (First, Middle, Maiden Surname)
Leah Kneisley 17. Father's Name (First, Middle, Last) ပ Jacob Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2113 Mason Hill Drive, Alexandria, Virginia 22306 Patrick Young (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Arlington National Cemetery June 16, 2010 1 K Burial 2 Cremation 3 Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signet to f Funeral Ferric Lic 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, signed by the attending physician and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s certificate has autopsy performed 2 No Yes 2 No 1 🔲 Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and ٥ 2880 1050 Perimeter Ro of person who completed cause of deat (Item 23a) (Type, Print) ALOUF 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Adolphus Russell Young 12:15 PM M Medical lime 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ₩ 2 □ F Days (Month, Day, Year) Months Hours Min. 577 50 2547 Director 73 March 1937 Virginia Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George Clinton 1 Pes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8709 Deborah Street 20735 United States hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 XXYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement. US Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Richard Young Genevieve Y. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Banks-Young (WIFE) 8709 Deborah Street, Clinton, MD Method of Disposition

1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery June 19, 2010 | Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria . Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 2 No After this certificate has been signed by the a funeral director, page 2 should be detached t 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? Yes 2 No death? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: ျ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Director: filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State) within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0041580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Kelso, M.D. 7503 Surratts Road, Clinton, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -Month nwood Medical 110 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, April 11. Country)
Maryland 219-03-6048 89 Director Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 264 11th Street 21122 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa Specify: White Year or Dates. WIII 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Insulation Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alvin V. Acree, Sr. Frances E. Chaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 11th Street Pasadena, Maryland 21122 Health Rachel Faye Dulski daughter permit. Page 1 and 2.
Department of Health
Important: If item 27
any injury or other tr
once. 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Meadowridge Cemetery June 24, 2010 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Ent - the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abundance and n signed by the attending physician and Id be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other ပ 1 Tyes 1 Phopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ddless of person who completed cause of death (Item 23a) (Type, Print) DRIVE Registrar's Signature . Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

LENWIND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 15 PM DERALD THON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City Town, or Location of Death Examiner Baltimore Genesis Eldercare - Heritager Center Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min 1 ▼M 2 □ F 216-18-3333 92 Director 27, 1918 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a State 28a-f show Dunda 1 k 1 ☐ Yes 2 X No Funeral Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21224 524 48th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 \mathbb{X} Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel 8 years Die Setter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot Anna English Herbert Anthony ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Coleman Daughter 526 48th Street, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition i of ... 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or june 25,2010 Dundalk, Maryland Sacred Heart of Jesus Cem. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, omplications that caused the death 🗸 o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Little nly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Box 68760, be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural **Division** 5 Pending investigation 1 ☐ Yes 2 No s after death Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

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Dundalk MA 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Camille J. Busby Year 5:45 Tune 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death tizens Nursing 1)e Harre tor Home Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M **X** X F Min June 28, 1909 075-18-1372 100 Country) Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director NV Clark Las Vegas 1 🗆 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1969 Hallwood Drive 89119 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2XXNo Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify 3 XXWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samue1 Patterson Callie Sadler Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Thelma P. Davis (Cousin) 607 Westgate Road, Aberdeen, MD 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Palm Valley View Cem 06/26/2010 Las Vegas, NV of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sound fally list so although if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other 1 Tes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? Natural 5 Pending iniury 1 Yes 2 No Accident Investigation after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Clara D. Baker 2010 6:50 P Medical June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Mays Chapel Timonium Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2×2√F Days Hours Min 219-10-9559 Director 1926 Usual Residence of Decedent items 23a or 28a-f shov per rit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown yinjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Baltimore Timonium 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12230 Round Wood Road 21093 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify.White 3€Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Rep. Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis Milerski Clara Jaskulski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Robust 3620 Rockberry Road, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation Donation Other (Specify) ic Crematory : 6/26/2010 | Glen Burnie, Mary 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, INc. 21211 Glen Burnie, Maryland 21. Signature of Funeral Service License 3631 Falls Road, Baltimore, 23a. Part 1. Ent r v e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or his rt failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide work?
1 Yes 2 No 5 Pending injury Investigation Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Corrilying Nurse Practioner. To the best of my knowledge, ductn operand at the time, date and plane, and the to the cause(s) and manner as stated mly une 29b. Signature and title of certifier 29c. License number DNI-R080210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles 6701 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Healthy and Mental Hygiene | | | For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nancy Belle Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest andallstown 101 alhonore 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Social Security Number Funeral Age (In yrs. last birthday) 8. Date of Birth Days 1-XM 2 X F 0572771944 213-46-0846 Director 66 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 5 COACH HOUSE DRIVE 21117 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced WHITE Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. marked other than "-College (1-4 or 5+) Elementary/Seconday (0-12) DIRECTOR MARKETING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 **KROME** HERLICH CHARLES SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1925 TURNBERRY COURT, FINKSBURG, MD 21048 CHERYL NOVAK / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI ZION CEMETERY: 06/20/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 'n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 ☐ Yes 2 ₩ 9 ☐ Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 - N Yes 8 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 A PR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Director: After this I in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signaty nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2010 D67650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ar vell aibi 40101d lart 2 anda listowin MD 2/133 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

#1,390, actd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sharon Ann Armstrong Boarman Month 4:12 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNIES HOSPITAL ST BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-54-1035 Jan. 10, 1949 1 ☐ M 2🗶 F 61 Months Hours Min. Maryland Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Catonsville MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 5 Arthur Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Noivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. Computer Programer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Jane Abbott Thomas Theodore Armstrong, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Wendy Weber 1055 5th Street; Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Atlantic Crematory 6/25/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Juneral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ LUNG CANCER METASTATIC disease or condition V-Ca-Medical resulting in death) Due to (or as a consequence of): **Examiner** PMEUNIONIEA WICK Sequentially list conditions, if any leading to in reading to in reading cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Directo for as a nonsequence or attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 1 Yes 2 ed by the a detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed 2 Z No Yes 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🛮 No 욘 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifie 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Valuet 24062 19,2012 & BINE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 AVENUE BALTIMORE 32. Registrar Signature State Registrar

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BOARMAN

Physician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Director

by Funeral

Completed

Be

2

Examiner

**Funeral** 

**Director** 

ıral", or items 23a or 28a-f show Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the <u>Medical Examiner muore</u>.

Baltimore, Maryland 21215-0036

with the Maryland

page 2 should be detached for use within 24 hours at To the Funeral D completed filled in

- 1	111. V to 1		2	325 York Road 「	Pimonium. Ma	rvland 210	93			
	23a. Part 1 Enter the disease, or comp shock, or heart failure. List only or	olical as that caused the death ne cause on each line.					Approximate Interval Between Onset and Death			
Н	Immediate Cause (Final disease or condition		VV KEKS							
	resulting in death)	Due to (or as a consequence of):								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ								
	that initiated events resulting in death) Last	Due to (or as a consequ								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	b. Was decedent pregnant								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3  24a. Was an autopsy performed autopsy performed by the conditions are contributed.										
produio	Diabetes				24a, Was an autopsy performeç 1 Yes 2 2	prior to death?	utopsy findings available completion of cause of			
)	25. Was case referred to medical			26. Place of Death (Chec	k only one)					
2	examiner?  1 Yes 2 No	Hospital: 1  Inpatient 2	ER/Outpatient 3 DO		ome 5 Residence		ecity) OSpice			
cale.	27. Manner of Death  12 Natural 5  Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of 28 injury M	c. Injury at work? 1  Yes 2  No	28d. Describe how in					
Cer	3 Suicide 6 Could not to determined	t and Number or F tate)	iural Route Number,							
ledical		vsician: To the best of my know niner: On the basis of examinationse Practioner: To the best of m			ice, and due to the cal	use(s) and manner	as stated.			
2	29b. Signature and title of certifier	Voll CRNA	29c	License number R125973	29d	. Date signed (Moi	24 20 10			

State Registrar 6701

N. CHARLES OF BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- WOC

NEUSSAJ 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death rosby, Preginala 3. Time of Death Month Physician/ :50 R M Medical Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ,0°C1 leat-thub If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Hours Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 snows 22.

Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural", or items 23a or 28a-1 snow any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g, Citizen of What Country? 12. Was Dece 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) dent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 21244 Informant's Name/Relationship (Type Baltimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Kid Sequentially list conditions, Examine Due to (or as a consequence oi): if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the signed filed in by the funeral director; page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 🗍 Yes 2 🗌 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗗 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) borch Bul 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20<sup>Year</sup>0 Harris Cole 23:10 Frankie 6 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Center Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2  $\square$  F Months Days Hours Min (Month, Day, Year) Director 64 214-44-5170 4-22-1946 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD na Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral S A 21216 3101 Mondawmin Avenue items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. P 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify "natural", 3 Widowed 4XXDivorced Completed Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Baltimore City Dept (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) of Public Works Security Guard llth grade permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada Harris Rubin Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ralto, MD 21216 19a. Informant's Name/Relationship (Type, Print) 3101 Mondawmin Avenue Balto, MD Denise Cole-Exwife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest 1 XBurial 2 Cremation 3 Removal from State 6-28-2010 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility March East F/H . Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 cn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Stat Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 *m*onths?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autops perfori this certificate Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Tes 2 **W**io 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital ...
within 24 hours after death.
To the Funeral Director: After thi
"maleted filled in by the funeral funeral Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ature and title of certific cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed N. CHARLES ST 01 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:400 M /Medical 4c. County of Death titution, give street and number) 4b. City, Town, or Location of Death Examiner 3altimo Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Gountry) Funeral 1 M 2 □ F Months Days Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Pres 2 □ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was D cedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ves 2 □ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r any injury or other traumatic event, It e Magne. Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. ..., Zip Code) 19a, Informant's Name/Relationship (Type. Print HIMOLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaluje of Funeral Service Lice see 22. Name and Address of Facility town Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** arcinoma 11 KM 5WM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner If any teacing to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 2 No 3 ☐ Probably certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 **1** No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1∐ Yes 2 **N**0 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death **Director:** And in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hourc the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor

To the Fune

completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

State

aven Boulevard

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06<sup>™</sup>216−2016<sup>ay</sup> Catherine A. Dolan 10:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bel Air Health & Rehab. Bel Air Harford . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Days 1 M 2 X F Months Hours Min. 06<u>M978;-</u>P1933 213-28-8099 78 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 Yes 2X No Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 303 D Tallpines Ct USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) af Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Bendix Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Daniel V. Dolan Mary Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Margaret Martin (sister) 1410 Gunston Rd Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State St. Ignatius Cem. 4 ☐ Donation 5 ☐ Other (Specify) 06-19-2010 Hickory, MD Signature of Fundal Service License <sup>22. Name and Address of Facility</sup> Schimunck Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final non-small cell king etastatic Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, having to immedia cause. Enter Underlying Cause (Disease or linjury Due to jor as a consuquence of Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Physician/Medical P.O. Box 68760 attending properties for use as 33 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 g signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performe 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work s after death.

I Director: A in by the fu 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours after the Funeral Dire mpleted filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗀 within 2

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c, License number 29d. Date signed (Month, Day, Year) D56545 17 30. Name and address of pereon who completed cause of death (Item 23a) (Type, Print)
SHIPI KHOSIA 615 W. MACPHAILRD # #106, BELAIR, MD 21014 KHOSLA W. MACPHAILRD 31. Date filed (Month, Dev. Year) 2 4 201 32. Registrar's Signature State arko

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 995 grne 2010 11:15 A M /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death cf mary and medical Examiner Battin N/A 1012 centi If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F Director n/a 15 6/15/2010 MD Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinating an entitled at Randlestown Baltimore MD Director ty Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21133 3710 Trent Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X o 14. Race - American Indian, 11. Marital Status African etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: American Specify. <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A 2 should be filed who and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ceaira Harrison Travis Diggs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum 3710 Trent Road, Randlestown, MD 21133 Ceaira Harrison/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mť. 6/26/10 Baltimore,MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examine choami Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical the as IF FEMALE: for use a If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 \(\overline{D}\) No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 2 4 2010 Agrana

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

22

Rene

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2010 0756 AM Ntoinette Dorsch June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARBUR Muspita timone 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours Maryland 54 Director 214 66 4852 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 4400 Ritchie Highway 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene. The marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Filipiak Dorothy Regina Fell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Baltimore, Maryland 21225 4400 Ritchie Highway Jerome G. Dorsch / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 06/21/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Tangral Service Lice Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pmysician/ MYOCARLIN disease or condition resulting in death) moreliste Medical Examiner ye MC COROLDERY MATERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a conseducine of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No this certificate 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 Yes 2 No 1- Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar BUKOVITE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I. BUKO

31. Date filed (Month, Day, Year)

JUN 24 2010

MD

0061438

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 SR. FRANK EDWARD Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE STELLA MARIS HOSPICE TOMONIUM If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Sex Days Hours (Month, Day, Year) v 25 1936 1**X** M 2 □ F VIRGINIA Director 228-38-5086 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "named 10b. County 10a. State 10c. City, Town or Location Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 BRETT COURT 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 XNo Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5:45 Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION WELDER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **BETTY** UNKNOWN **EPPS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILL PINE RD. BALTIMORE. DUANE EPPS/SON MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 【XCremation 3 ☐ Removal from State JUNE 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 6-23-2010 BALTIMORE, MD Signature of Funeral Service bio 22. Name and Address of Facility
WILLIAM C. BROWN COMM. F.
321 S. PHILADELPHIA BLVD. Part 1, Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No FRANK Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title ned (Manth, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

10d. Inside City Limits

P.A. MD 21001

Day

Year

Approximate Interval Between Onset and Death

1 🗌 Yes 2 💢 No

5:45 pM

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

filed (Month, Day, Year)
JUN 2 4 2010

CRNP

2300 DULANEY VALLEY RD.

32. Registrar's Signatur

TIMONIUM, MD 21093

		-	For State Registrar	State of Mary		artment of F <i>rtificate of L</i>				may see an		
	BI	,	Decedent's Name (First, Middle, Last	st)		timodito or E		2. Date of Death		3. Time of Death		
	Physicia Medic		Edward John Fracz			<del></del>		06-121-2		600 А м		
	Examin	er	4a. Facility Name (if not institution, give 702 Shore Drive	street and number)		4b. City, Town, or Joppa	Location of Death		4c. County of Dea Harford	th		
	Funeral Director		214-22-3233	77	yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	9. Bit Co	thplace (State or Foreign untry) MD			
	and show	ō	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryli 28a-f: otifiec	Director	MD Harfor	d	Joppa	а				1 ☐ Yes 2X No		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral D	10e. Street and Number 702 Shore Drive				085		0g. Citizen of What Co	ountry?		
900		þ	11. Marital Status  1 □ Never Married 2 ☒️ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.	? If Yes, specify Cuban, Mexica			in? (Specify Yes or No- Puerto Rican, etc.)  14. Ra Bla Specif		e - American Indian, sk, White, etc. White		
Baltimore, Maryland 21215-0036	ithin 72 hov ene. r <b>than "nat</b> t <b>he Medic</b> a	Completed	15. Decedent's Eigenstage/Seconday (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired) Steel Worker			ring most of working		Industry Stee1		
land 2	l be filed w lental Hygi rked other lic event, t	a)	17. Father's Name (First, Middle, Last) Stanislaus Fraczk	owski			18. Mother's Name Stefania					
, Mary	nd 2 should salth and N n 27 is ma er traumal		19a. Informant's Name/Relationship (7. Tony Barnes (Son)	ype, Print)		ng Address (Street & Trails W			City or Town, State, Zi	p Code)		
imore	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆 4 🗋 Donation 5 🗀 Other (Speci	Removal from State	20b. Place of Dispo cemetery, crea Holy Ros	osition (Name of matory or other places ary Cem.	ا (م		20c. Location - City of Baltimore,	·		
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral Home of Inc 610 W. MacPhail Rd BelAir, MD 21014  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  App									
	Pnysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or at a consequence of):									
-	Medical Examiner	Ļ	resulting in death)  Sequentially list conditions,	ase		years						
	cuted ind transit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. End S	fage 7	Renal	Disea	se_		months		
200	icate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a co	Libri	lation	า			years		
687	ertificat ding ph se as th	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d. Date of de	aliveny		
Box	he death c y the atter iched for u	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown		Month	Day Year						
ds, P.O	requires that the death certific been signed by the attending I should be detached for use as	by	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying cause giv	ren in Part I.		es 2 4 No 3 F	o the cause of death?  Probably 4 Unknown		
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certification after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed	Aug. 2012			-		24a. Was ar autops perform 1 \sum Yes 2	y prior to ned? death?	utopsy findings available completion of cause of		
<u>ta</u>	ician: Sertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (Check					
of V	g Phys er this c	e: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatie	of 28c. Injury	4 ∐ Nursing Ho / at		nce 6 Other (Special Office of Special Office of	cify)		
on	Attending P death. ctor: After t y the funera	ficat	1 Natural 5 Pending 2 Accident Investigation		ear) injury	M 1 □	? Yes 2□No					
Divisi	tal or Att irs after d al Direct led in by t	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 ☐ Medical Exam only one) 3 ☐ Certifying Nur	sician: To the best of my iner: On the basis of exam se Practioner: To the best	ination and/or inves	stigation, in my opinion death occurred at the	on, death occurred a e time, date and place	t the time, date and be, and due to the	d place, and due to the cause(s) and manner as	cause(s) and manner stated. s stated.		
	To To cor		29b. Signature and title of certifier			D O	06582	7	9d. Date signed (Mont	1 O		
			30. Name and address of person who all the state of the s	Ries 6	500 Ches	apeake -	Dr Bu	lair	mD a	21014		
	Stat Registra		IIIN 2.4	32. Regis ar's	A. A.	parker						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 13:45 2010 Ada Jean Fitzgerald 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Union Memorial Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4-4-19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. 1 M 2 K 78 Director 224-40-8162 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director notified Baltimore MD 1. Tyes 2 No 10e Street and Number 10f. Zip Code ö 10g, Citizen of What Country? must be Funeral , or items 23a USA 21202 Federal Street 432 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner Black White etc. δ 1 Never Married 2 Married Yes 2 No Yes, Give X Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 ₩idowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) n/a llth Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဝ Corrine Jennings James Irby and l 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Thorndale Ave.Baltimore, Md. 21215 3011 Valerie Floyd- Daughter other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott Page 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 6-25-2010 4 Donation 5 Other (Specify) Landsdowne, Zion Μt 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service License 1101 E.North Avenue Baltimore, MD 21202 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? be detached for Month Day Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate | 21 1 ☐ Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 💢 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniun 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PM

MD

d ay

day 2

eak

Year

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 03 2438946-BH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OUSSER RAYEN East Muiscerick State Registrar ODICINAL

		For State Registrar		State o	of Marylan		partment of F ertificate of I		Mental Hy	ygiene Reg. No.	010	19758	
Div1-1		Decedent's Name	e (First, Middle	e, Last)					2. Date of D		Year	3. Time of Death	_
Physicia /Medic	_	John	James	1	Germenk	co		<u>-</u>	June	16,	2010		_
Examin	er		n, give street and nu	4b. City, Town, or		th	4c. County of Death  Howard						
Funeral		5. Social Security N		ert Road	7. Age (In yrs.	last birthda	Ellicott  ay) If Under 1 Year	If Under 24 Hrs			9. Birtl	place (State or Foreign	1
Director		205-01-88	889	1 🖾 M 2 🗆 F	90	Yrs	Months Days	Hours Min	Aug. 9	, 191		nsylvania	
and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or	Location					10d. Inside City Limits	_
the Maryland 28a-f show polified at	to	MD	Howa	rd	F	11ic	ott City					1 □Yes 2 No	
th the	Sirec	10e. Street and Nur		.ru	1	TITE	10f. Zip Code			10g. Citiz	zen of What Co	intry?	
er death wi	ral	12162 Mot	unt Alb				2104				USA		_
the to the	by Funeral Director	11. Marital Status 1 □ Never Marr		ried Armed Fo	2 🗆 No	S. 1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>□Yes 2対No</li> </ol>	ispanic Origin? ( in, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		14. Race - Amer Black, White Specify: Wh		
permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", cany injury or other traumatic event, the Westian Exagone.	eted b	3 Widowed	15. Deceden			16a. De	ecedent's Usual Occup	ation during most of wo	rkina		nd of Business/I	ndustry	
d within giene.	Completed	Elementary/Seco	, , ,	College (			ive kind of work done of e. DO NOT use retired er/Operator			Trans	sportat	ion	
be file tal Hy d othe	Be	17. Father's Name							me (First, Middle		Surname)		
ould the narke	ဥ	Lawrence				T			Jermenko		. T O4-4- 7	7- O- d-1	_
rd 2 sh Ith and 27 Is n traun		19a. Informant's N		Germenko	Wife		ailing Address (Street) 62 Mount A						
es 1 ar of Hea fitem 2		20a. Method of Dis	position	3 Removal from	20b. F	lace of Dis	sposition (Name of crematory or other place	e)	Date	20c. Loc	cation - City or	own, State	
it. Pagi rtment rtant: It njury o		4 ☐ Bonation	5 Other (S	pecify)	Lo	ıdon	Park Cemet	,			-	laryland	_
permi Depai Impor any ir		21. Signature of Fu	ineral Service	Licergae	n lox	_ ]	Funeral Hor	ne of Ca	tonsvil	le, In	nc.		
		23a. Part 1. Enter t	the disease	complications that	aused the deat	n. Do not	1630 Edmor	ng, such as cardia	ic or respiratory	arrest,	VIIIE,	Approximate Interval Between	_
Physician		Immediate Cause disease or condition	(Final	a	Ch	101	11c Reno	1 tail	ure			Onset and Death	
/Medical Examiner		resulting in death)		Due to	(or as a conseq	uence of):						7000	
led isit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	nditions, nmediate erlying	b	(or as a conseq	uence of):							Ī
icate be executed physician and the burial-transit		that initiated events resulting in death)	s Last										
cate be ohysici the bu	dical			d									_
leath certific attending p	/Me	IF FEMALE:		23c. If yes, ou	tcome of pregna	ancy			***	2	23d. Date of del	verv	T
e death the atter	Physician/Me	2 Not Needed the pregnant at time of death   1									Month	Day Year	
that the ed by detach												the cause of death?	Т
v requires that the d been signed by the should be detached	ted by		ony es	tive he	art f	mli	Atral	abrillat	101	Yes 2	No 3□ Pr	obably 4 🗌 Unknown	
elawr hasbe ge 2 sh	Completed								24a. Wa aut	s an opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of	
tn: Th ifficate or, pag	မ င်	25. Was case refer	rred to medica					26 Place of Do	1 □ Yes	2 No	1 □Yes	2 No	_
ysicia iis cer direct	To B	examiner? 1 ☐ Yes 2		Hospital:	Inpatient 2	ER/Outpa	itient 3 DOA Oth	er: _	Home 5 Re		0 □ Other (Spe	oify)	
nding Pt ath. r: After the e funeral	ation:	27. Manner of Deat  1 Natural 2 Accident	th 5 □ Pendir investi	9	of Injury oth, Day, Year)	28b. Tim Inju	ry Worl	y at k? Yes 2 □ No	28d. Describe	e how injury	y occurred		
al or Atte s after des I Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	ined Zee. Place	e of Injury - At ho ling, etc. (Special	ome, farm,	street, factory, office		28f. Location City or To	(Street and own, State)	d Number or Ru )	ıral Route Number,	
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)		Examiner: On the I			eath occurred at the ti or investigation, in my o						
To the comp	Me	29b. Signature Ind	Aitle of certifie	Melle	_wo		29c. Licens	e number 4613		29d. Dat	te signed (Mont	h, Day, Year)	
10		30. Name and add	ress of person	who completed cau	se of death (Iter	23a) (Ty	pe, Print)	Brun	Rd	Ella	ridge	MO 21075	-
Sta		31. Date filed (Mor	nth Day Year)	0 8 11 9	Registrar's Signa	iture	,						
Registr		JUN 67	2010	100,000	7								

AMEND ITEM#16a, b. perFH G904.61/24/2010 WS Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Harrison-Miller Tijauna 6:05 PM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** NOF Himore Thwest g. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 L Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 2 Yes 2 No TIMORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced : Shound be and Mental Hygiene.
27 is marked other than "natural"
. ∵ - the Medical E; Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. King of Business Industry Sor Social Services 15 Decedent's Education (Specify only highest grade completed) Income Maintenance Supervisor Elementary/Seconday (0-12) College (1-4 or 5+) Be Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Bast) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mille HIMOZ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State y or other place 1 Usurial 2 Cremation 3 Removal from State emetery, crep altimore 4 Donation 5 Other (Specify) Si atur of funeral Service Lic MD 21287 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Physician Hepatocellular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No After this certificate has been signed by the atter funeral director, page 2 should be detached for it 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗹 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Vother (Specify) + huspice Other: 1 🗌 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 124 hours a Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completed fil 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 115 Rajapahre M.D DUUS7465 6/20/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Smith Av., 5-235, Baltimore, MD, 21209 N.S. Rajapakse, MID. 31. Date filed (Month 32. Registrar's ignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 06:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MIDI a timale If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Months Hours Director or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Pes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, et 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 Maryland 21215-0036 2 No "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (7-4 or 5+) Be Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, ဂ t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) tair Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 Other (Specify) permit. 21. Si natur of Funeral Servic-Lio nse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Antro Sepral Immediate Cause (Final Onset and Death Physician/ lassine disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it my boding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to jor as a consequence of eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🖔 No 3 □ Probably 4 □ Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FAR PAO Sarabchi Umon Me

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 20, 2010 **Physician** 5:00 ам ROMAN HERASYMOWYCZ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE MAPLES OF TOWSON TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. OCT. 10, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□F POLAND Yrs. 109-28-0709 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Counts ehow 1 end 2 should be filed within 72 hours after death with the Maryla Health and Mantal Hygiene.
The strip marked other then "nature!; or items 23e or 28a-1 ehove the transful and the transful event it is Madical Examinate must be notified as 1 ☐ Yes 2X No Director MD BALTIMORE TOWSON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7925 YORK ROAD 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 College (1-4or 5+) 5 + Elementary/Secondary (0-12) CHEMICAL ENGINEER BREWERY Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SYLVESTER MARTHA HERASYMOWYCZ KOLTUNUK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) KANDACE SCHERR/ ATTORNEY 1400 FRONT AVE., SUITE 200, LUTHERVILLE, MD more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of important: if eny injury or once. ROSE HILL CREMATORY 6/26/10 LINDEN, NEW JERSEY 4 ☐ Donation 5 ☐ Other (Specify) Balti 21. Signature of Funeral Sarvice Licenses 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2011 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) MAKNOWN Examiner De S uential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit UNK nown The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year signed by the at 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 ☐ Yes 2 ♠ No ٩ Jo this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ò 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120 10061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AL-AZZAWI, M.D. 9103 FRANKLIN SQUARE DR., SUITE 301, baltimore, MD 31. Date filed (Month, Day; Year) 32. Registra's Signature State Registrar 24

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ERALD Physician/ JUN 5 1838 PM 2010 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL N/A BALTIMORE CENTER 5. Social Security Number r 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 7. 1947 Months Hours Mary land 217-50-3999 **Director** 62 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Parkville Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or with Funeral 21234 USA 1727 Red Oak Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify; White 3X Widowed 4 □ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Marie McCullough Henry William Hau permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Brook Valley Court Freeland, Maryland 21053 Kathleen Wilt, Sister Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 06/23/10 Baltimore, Maryland Metro Crematory Inc.: 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a, Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY ARREST Physician/ HOURS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ō in the past 12 months? Day Month Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>|</u>2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check edical Examiper: On the oasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. itle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an RES-000 22,2010 MD. PhD TUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean Agbor - Enoh 4940 E EASTERN AVENUE BALTIMORE, MD. 21224 Sean Agbor. Enoh 3 31. Date filed (Month, Day)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 46PM 2010 DENISE CASSANDRA HOLLMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Sg 5. Social Security Number vare Hospital Center Vear If Under 24 Hrs. baltimore If Under 1 (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XX Days 217-78-3055 Director 57 1953 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Mexical Examinar must be natified at 1 ☐ Yes 2XXVo Director MARYLAND HOWARD CO COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5694 THICKET LN by Funeral <u>2</u>1044 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1∐Yes 2∭XNo Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. 0yrs N/A N/A permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygi Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER DOUGLASS HOLLMAN LOIS C. JOHNSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5694 Thicket Ln., Columbia, Md., 21044 Larry D. Hollman/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06-23-10 BALTIMORE, MARYLAND ARBUTUS MEMORIAL e of Funeral Service License 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. W NORTH AVENUE Mu mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nly one cause on each line. 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final HCutc My OCard

Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, lephresulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month signed by the a d be detached for 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊕Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 06/16/2010 20061662

Registrar

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State

9000 Franklin Square Drive Baltimore MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Haasen

lenry Hagey		Si 1- For State Registrar	tate of Maryland	-	rtment of tificate of		na ivient	tai Hygie		. No. 201	0 19764
Physici Medical Exami		1. Decedent's Name (First, Midd Henry J. Hage							ate of Death fonth Ine 17, 20		3. Time of Death 1704 hrs
		4a. Facility Name (if not institution 1806 Harford Road		)	4	b. City, Town, o	r Location o			4c. County of Do	eath
Funeral Director		5. Social Security Number 216-42-0151	6. Sex 7. An	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Ye		_	Date of Birth	E-0	Birthplace (State or reign Country)MD
any		Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Location	on					10d. Inside City Limits
À .	for		1timore	I	Baldwin	10f, Zip Code				g. Citizen of What 0	1 Yes 2 No
the Mary a or 28a	Director	10e. Street and Number 13411 Fork Rd				2101	3			JSA	ountry?
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 N	1   X   Yes 2		If Ye	s Decedent of H	n, Mexican,			White, et	
urs after itural",	Ď	3 Widowed 4 Dir 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade co	mpleted)	16a. Decedent	Yes 2X N	ation (Give k		done	Specify: \	White ss/Industry
5-0036 lled within 72 hours after Hygiene. I other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	) College (1-4 or 2	5+)	Lieut	ost of working life	e. DO NOT	use retired)	Ī	State Po	lico
다 한 를 뜻 를 해		17. Father's Name (First, Middle	e, Last)	<u>[</u>	Lieut	Chanc		•		aiden Surname)	1100
2121 Mental Mental marked c event,		Henry J. Hagey, Sr. Margaret Hensen  9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip									tate, Zip Code)
		Donna A. Hagey  20a. Method of Disposition	(Wife)	20h B		Fork R		dwin,		and 21013	
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mentall tant: If item 27 is marked or other traumatic event,		1 Name Burial 2 Crematio		tate cr	rematory or oth	er place)			1	Fallston	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signatur of uneral Se			22. N	ame and Addres	s of Facility	Schim	unek I	Funeral H	ome of BelAi
Physician		23a. Part I. Enter the disease, o failure. List only one cause	or complications that caused	d the death.						LAir, MD st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	87. 30	Immediate Cause (Final disease or condition resulting in death)	B.A. data la lacionale.								Death
	_	Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c							<del></del>	
scuted and transit		events resulting in death) Last	d.							**	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	<b>l</b> edical	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome	me of pregn	ancy					23d Date of deli	verv
687( certifica nding pl	ian/N	23b. Was decedent pregnant in t past 12 months?	the 1 Live birth  4 Pregnant a		2 Fet	al death 3 ner (Specify)	Ectopic	pregnancy		Month	Day Year
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cords law requi has been 2 should	Completed							_ [	24a. Was ar autopsy perform	prior	autopsy findings available to completion of cause of
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I		25. Was case referred to medical	al				e of Death (	(Check only o	Yes 2		
Vita  hysician  this cer	To Be	examiner?  1  Yes 2 No	Hospital: 1 Inpati		ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursing Ho	me 5 R	esidence 6 🗸 0	ther: Scene
<b>—</b> # , ^ #			28a. Date of Inj (Month Day Jun 17, 2010	ury Year)	28b. Time of In 1655 hrs		ury at Work′ Yes 2 ✔	Mot		w injury occurred nvolved in colli	ision
ViSi or Att fter de Direct	Certification:	3 Suicide 6 Cou	28e. Place of I 28e. Place of I (Specify) Ma			t, factory, office	building, etc	c. 28f.	Location (Store Town, Sta	reet and Number or ite) oad, Bel Air, MD	Rural Route Number, City
ie spi		29a. Certifier 1 Certifying F	Physician: To the best of n	ny knowledge	e, death occurr	ed at the time, o	date and pla	ce, and due	to the cause	(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 ✓ Medical Example 29b. Signature and title of certific	aminer: On the basis of exa and manner stated ier	amination an	a/or investigati		n, death occ se number	curred at the		nd place, and due to 29d. Date signed (	
		9 ~	1.1/	/		0.C	.M.E.			June 18, 2010	
		30. Name and ad ress of person Jack Titus MD. De	n who impleted cause of puty Chief Medical E	-		n Street, Ba	ltimore, N	MD 21201			
S Regis	tate	31. Date filed (Month, Day, Year,	32. Regis	ar's Signatur	e A. A	barker					
ricgis	Lists	JUN	ZYZUIU /	The Bearing	1. 17						

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25,26,27 and 29a per dr., g904,06/24/2010dhb Reg. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Edward Holley 2010 June 2:30  $P^{M}$ /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Hospital Prince Georges Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 14, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 579-56-8991 63 Pennsylvania Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Experiment reast be its lifted at Prince Georges Capitol Heights 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 61st Street 20743 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Black, White, etc. Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual OccupationUnk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharlet Onyemenem - guardian 805 Brightseat Road; Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☑ Other (Specify) In State 21. Signature of Euneral Sea <sup>22</sup> State Anatomy Board; 655 West Baltimore Street DUC. ector Baltimore, Maryland 21201 I. Enter the disease or complications that caused the death. Do not enter the mooe of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEMSiAn **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5000 Symentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed PAELMON, 7 and Due to (or as a consequence of) the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Tyes or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 255703 06,14,2 True: Cheverly MD 20785 n who completed cause of death (Item 23a) (Type, Print) 32. egistrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

JUN 2 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc g905 7-1-10 yt
State of Maryland / Debarrment of Health and Mental Hygiene

For State Registrar

Amend Item 23aPtII per dr., g904, 06/24/2010dnb

Registrar

Amend #5 Per INF G919 9/06/29/1/1/10app of Death

Reg. No. 7 1 2. Date of Death Month 15 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Hughes Marie Nora 16. 010 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3206 Northway Drive S218 8 4 0 N 0409 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 □ M 2 🔀 F Months Days Hours Min (Month, Day, Year) 1943 66 Director 00 Usual Residence of Decedent f show and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits Director MD 1 Ses 2 No 10f. Zip Code 21234 10e, Street and Number 10g. Citizen of What Country? Funeral 3206 Northway Drive U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. White Armed Forces 1  $\square$  Never Married 2  $\square$  Married Š Yes 2 **2** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Be Page 1 and 2 should be filed vent of Health and Mental Hygiant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bridgett Brennan Bernard Ouinn traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 7834 Edsworth Road, Dundalk, MD 21222 David Hughes/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. Beltsville, MD 06.17.10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1443 22. Name and Address of Facilit CAFA/Stephen D. Lohrmann, PA MD 21286 8717 Green Pastures Dr. BAlto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LYMPHOM A Enysician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): TASTASIS que, tially list sonditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day Year 4 Pregnant a
9 Unknown Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending enysterate. The Hours after death.

To the Funeral Director. After this certificate has been significant of the Funeral director, page 2 should the completed filled in by the funeral director, page 2 should the funeral director. 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number DO064369 16TUNE Desur Mas 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8113 HARFORD ROAD, PARKVILLE, MIDZIZZLI DRAGOS POPESCU 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JUN 24 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month June 2ďľo Thomas Anthony Herrity 6:11 Рм /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartland Hospice Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1939 1 ☑ M 2 □ F Maryland 212-36-1300 70 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, Item Mudical Examines required. 7575 E. Howard Road Funeral Glen Burnie 21060 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates; 1 Never Married 2 Married 27 is marked other than "natural", or it traumatic event, I'm Mudical Expris Completed by 1 □Yes 21 No Specify. white Specify: 3 x Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
unk unk police officer DC Park Police 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Pauline Vye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Herrity - son 12 Southwood Road; Enfield, CT 06082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State  $\begin{array}{cccc} 1 \square \ \, \text{Burial} & 2 \square \ \, \text{Cremation} & 3 \square \ \, \text{Removal from State} \\ 4 \square \ \, \text{Donation} & 5 \cancel{K} \ \, \text{Other} \ \, \text{(Specify)} & 1n \ \, \text{State} \\ \end{array}$ 21. Signa ure of Funeral Service, licensee <sup>22</sup> Name and Address of Facility Board; 655 West Baltimore Street Baltimore, Maryland 21201 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for se's consequence off

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

Physician/Medical ≥ Completed Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tra signed by the attending physician be detached for use as the buria eral Director: After this certificate has been sign filled in by the funeral director, page 2 should be after death. within 24 hours a

Division of Vital Records,

IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 3 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA # ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

2 🗆 No

Due to (or as a consequence of):

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier recrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2010 D54749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Reilly,MD, 801 Toll House Ave., D-1,Frederick,MD

State Registrar 31. Date filed (Month, Day, Year)

JUN 24 2010

32 Registrar's Signature

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4.10PM 2010 Albert McKinley Hunt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 70 220 36 3729 12/28/1939 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7307 Anon Lane 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) 12th College (1-4or 5+) Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Vernon 2 Jean Vernon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Hunt / wife 7307 Anon Lane Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 06/22/2010 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC DESTRUCTIVE PULMONARY DISCASE MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Little to for as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□Yes 2☑No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2, 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural

and burial-trar P.O. Box 68760, attending physician for use as the buria signed by the a d be detached f nis certificate has been s director, page 2 should After this filled in by the funeral al or Attending F s after death. I Director: After

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RESIDENT PHYSICIAN

29c. License number 24060 29d. Date signed (Month, Day, Year) 06/19/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 S'CATON AVE, BALTIMORE, MD 32. Registrar's Signatur

State

DHMH 17 Rev 1/2001

Medical

24 hours a Hospital

the within To the completely

**Physician** /Medical **Examiner** 

**Funeral** Director with the Maryland 28a-f show

ed other than "natural", or items 23a or 28a-f shore event, the Medical Examination to making at · death v

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. Ma once. permit.

**Physician** 

/Medical

Examiner

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June Frederick Franklin Huster, Sr. 2010 3:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1915 Stevens Drive Queen Annes Chester Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min. 218 42 2359 1070871944 65 Marviand **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Chester Maryland Oueen Annes 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be. Funeral 1915 Stevens Drive 21619 U.S.A. filed within 72 hours after death al Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Viet Nam Completed 3 X Widowed 4 Divorced White Year or Dates. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Warehouseman J.P. Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Huster Hazel Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 1915 Stevens Drive Kelly White / Daughter Chester, Maryland 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem. 06/22/2010 Crownsville, Maryland 21. Signa of Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death conge Friysician/ evo. disease or condition resulting in death) 11255 Medical Due to (or as an onsequence of): Examiner lears monde Secrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ulmonary obstruc Chronic attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No ed by the a detached i g Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 cate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 WNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0055127 Rala-ones 2010

State Registrar 202

Coursevall Dr. Suite 101 Centruille MD 21617

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

to. Malary M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June Kenneth James Ireland  $20\overset{\scriptscriptstyle{\mathsf{Year}}}{10}$ 6:31 А. м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 11/07/1957 1 🔀 M 2 🗆 F Months Days Hours Country) Maryland 52 217 72 7040 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 419 Annabel Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Electrical Contractor Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert W. Ireland ပ Billy Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise A. Ireland / wife 419 Annabel Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 06/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Signature of Funeral Service Licens Gonce Funeral Service, Ritchie Highway als Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause open ch line. Approximate Ipterval Between Immediate Cause (Final net on Coath Ph sician/ disease or condition Medical resulting in death) as a consequence of **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 100 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes Other: 2 (200) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide
Homicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Xvertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) N. CHARLES ST. BALTIMORE MO

DHMH 17 Rev 7/2009

State Registrar J

31. Date filed (Month, Day, Year)

WOLF

32. Registrar's Signature

			1 - State of M	laryland / l		rtment <i>tificat</i> e			and M	lental Hy	giene Reg. No	ZU.	0	19771
	Physicia		1. Decedent's Name (First, Middle, Last)  VEKNUN_ JOHNSON							2. Date of De			Year 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)  WNIV. OF MARYLAND MEDICAL	CONTER		4b. City, Town, or Location of Death BALTIM ORE					40	. County o		
	Funeral Director			ge (In yrs. last birt	thday) Yrs.	If Under 1 Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir 06-03-	th 1'948		9. Birthp	place (State or Foreign MD
aryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ector	Usual Residence of Decedent  10a. State 10b. County  MD Harford	n or Loc bing						10d. Inside City Limits 1 ☐ Yes 2 X No				
th the M		Funeral Director	10e. Street and Number			10f. Zip (						itizen of W	hat Coun	try?
36 after death wi	al", or items 2 xaminer mus		708 W. Baker Ave.  11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 ☒ Yes 2 □ If Yes, Give		If	210 /as Decede Yes, specif	nt of His y Cuban	, Mexican	in? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Specify:	- Americ k, White, k	etc.
Maryland 21215-0036	ene. r than "natura the Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 1 2)	5+)	(Give k life. DC	dent's Usual Occupation kind of work done during most of working O NOT use retired) ineer					16b. Kind of Business Industry  Lucent Tech.			
land 2	fental Hygi rked other tic event, 1	To Be	17. Father's Name (First, Middle, Last) Vernon P. Johnson, Sr.					18. Mothe		(First, Middle,				
, <b>Mary</b> d 2 should	alth and M 127 is ma er traumal		19a. Informant's Name/Relationship (Type, Print) Anne Johnson (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 708 W. Baker Ave. Abingdon, MD 21009									ate, Zip C	Code)	
Baltimore, permit. Page 1 and	Page 1 and nent of Hea ant: If item iry or other		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place o cemete. Bayvi	ry, crem	atory or oth	ner place			-2010		ocation - 0	•	
Balt permit.	21. Signature of Service 22. Name and Address of FacilitySchimunek Inc 610 W. MacPhail Rd E									munek Rd Be	Fune 1Air	ral I	Home 2101	of BelAir  4
	ysician,	8 17			not ente	the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
	Medical kaminer			a consequence	of):									
uted	d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	cause. Enter Underlying Cause (Disease or iinjury that initiated events  C.										
<b>60</b> ate be exec	physician and the burial-transit	dical Ex	resulting in death) Last  Due to (or as	a consequence	a consequence of):									_
P.O. Box 687( that the death certifical	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med		2  Fetal death at time of death		Ectopic pro		,				23d. Date Mon		ery Day Year
IS, P.O.	signed by	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to										•	
Division of Vital Records, all or Attending Physician: The law requires	cate has beel , page 2 shou		NICM; atrial fibrillation (non-ischemec ardiomyopathy)							24a. Was auto perfo 1 \square Yes	psy ormed?	pi de	/ere autoprior to coreath?	osy findings available impletion of cause of
Vital ysician	is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat	tient 2 🗆 ER/Ou	utpatient	3 🗆 DOA	Othor	ce of Deat		only one) me 5 □ Resi	dence (	6 □ Other	(Specify)	1
on of ending Ph	aath. or: After th he funeral	Certificate:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation		Time of injury	280 M	c. Injury work? 1 🔲 ۱	at	2	8d. Describe h				
Divisi	irs after de al Directo led in by t			jury - At home, fa cc. <i>(Specify)</i>	arm, stre	et, factory,	office	_	1	28f. Location (\$ City or Tov			r or Rural	Route Number,
the Hosp	hin 24 hou <b>the Funer</b> mpleted fil	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/o	or investi	gation, in my eath occurre	y opinior ed at the	n, death oc time, date	curred at	the time, date a	and place le cause(	e, and due s) and mar	to the cau	use(s) and manner stated.
٠	wit 70		29b. Signature and title of certifier MD				License P 24	355	,			Time		2010
			30. Name and address of person who completed cause of a Anorea Hunna II S. E	death (Item 23a) ( にてみい ST			8	KLTIM	IURE	, MD	21	201		
	Stat Registra		31. Date filed (Month, Day, Year)— 32. Registr	rar's Signature	1.4	barka								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jackson JoAnna 5:45 PM 2010 June Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner na Union Memorial Hospital Baltimore Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 XF Months Hours Min. 2-7-1949 Country) Director 219-52-4799 S.C. 61 Usual Residence of Decedent fshov 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 □ No Baltimore MD na 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral S U 1035 N. Fulton Avenue 21217 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ filed within 72 hours after 1 🗆 Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working na life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse AA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Odessa Statis oseph Brayboy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1035 N. Fulton Avenue Balto, MD 21217 Pamela Curtis-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 6-26-10\_ Randallstown MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H MD 21202 Balto, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
~ 3 LL US Immediate Cause (Final Physician, metastatic year disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Directo for as a consequence of If any, leading to immedicause. Enter Underlying nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital or Attending Phys 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 124 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Praction or To the post of my in cycledge death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioners To the best of my knowledge, death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number hulfa AT 2438946 June 19,2010 · MD

Registrar
DHMH 17 Rev 7/2009

State

NEITA

31. Date filed (Month, Day, Year)

JUN 2 4 201

PKWY

BALTIMORE, MD

UNIVERSITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E

32. Registrar's Signature

KALARIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 **Physician** June 18, 8:30 P M Geraldine Jefferson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 2918 Dungate Road Pasadena 1 Year | If Under 8. Date of Birth (Month, Day, Year)
Nov. 28, 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Hours Yrs Nov. 1930 Maryland **Director** 217-26-6018 79 Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 1∩a State 10b. County 10d. Inside City Limits 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notitled at 1 □Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 2918 Dungate Road 21122 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 N/A Own Home Homamaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William . Everett Talbott Edith Virginia Harris ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Jefferson, Jr. (Son) 22 Melville Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Memorial Pk. 6/22/2010 Glen Burnie, Maryland 22. Name and Address of Facility. McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Fureral Service Licensee 21122 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, arck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner IR Gequentially net conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) agina burial-trar Due to (or as a consequence of): Box 68760, or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 2 No 1 🗆 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No of Vital 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After **Division** 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year)

Registrar
DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 2 4 2010

Im MA

32. Registrar's Signature

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 22, 20ใง Jacqueline Parks Johnson 5:25 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
Aug. 24, 1938 1 🗆 M 2 🗶 F Months Days Hours Country)
Maryland Director 215-38-1582 71 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Carney 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 2822 Ontario Avenue or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 Yes 2X No Specify: Specify: white 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Union Memorial 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot 2010 မ Henry W. Parks Sarah Creamer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health a 2822 Ontario Avenue-Carney, Maryland 21234 John Johnson, Jr-spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel and Cremation Ser Belair 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUNE ò Important: I any injury o Forest Hill, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Charel and Cremation

880 Harrford Road Parkville, Marylar

23a. Part 1. Enerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of death failure, List only one cause on each line.

Immediate Cause (Final disease or condition) 22. Name and Address of Facility.
Evans Funeral Chapel and Cremation Services
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) LIVER CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 3 Probably 4 Unknown JACQUEL INE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ours after death.

eral Director: After this certificate I filled in by the funeral director, pag med? 2 🔼 No 1 Tyes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:00 A.M Sterling T. Johnson, Sr. 20/15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med. Ctr. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F Days Min. Hours 1 2 - 1 7 - 1 9 2 4 85 Director 218-12-0838 MD Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 ☐ Yes 2 🔀 No MD Prince Georges College Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6100 Westchester Park Drive Apt 1412 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No ō ģ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give "natural". Specify: 3 Widowed 4 Divorced Completed 44-48 Black Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical" Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering US Government Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any injury or other traumatic ever ဂ္ Samuel Johnson Mary Viola Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Johnson Wife 7869 Crilley Road Apt 428 Glen Burnie, MD 21060 20a. Method of Disposition 20b. Flace of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Vet. 6-25-2010 Cem. Crownv1: Crownsville, Maryland 21. Signature of Funeral Service 2Domaidsons Funeral Home & Crematory, M01176 1411 Annapolis Road Odenton Maryland 21113 23a. Part 1 Inter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 ☐ No sate has been signed by the page 2 should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Other: ပ Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of p rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 32. Reg Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 3. Time of Death 2. Date of Death June Physician /Medical own, or Location of Death We dot institution, give street an 4c. County of Death **Examiner** anor 8. Date of Birth (Month, Day, Year) Jan. 25, 1 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 D F Days Hours 70 1940 Virginia **Director** 213-40-0115 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director Maryland N/A XXYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rock Rose Avenue 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the amy injury or other traumatic event, the ones. Dental Technician Dentistry 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Lester Lee Johns Mary E. Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Brown Son 1308 Morling Avenue, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ↑2 Cremation 3 ☐ Removal from State 4 Donayon 5 ☐ Other (Specify) Atlantic Crematory 6/24/2010 | Glen Burnie, Maryland 21. Sign, tur / Funeral Service License 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heavy **Physician** Congestine /Medical Due to (or as a consequence of): xaminer Comany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Demen Due to (or as a consequence of) Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | → Thknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2: autopsy performed' Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I

State

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mp

32. Registrar's Signature

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A. HASHMI

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Registrar

MD

29c. License number

DZIY6Y

N. EUTAW ST SNIE 308 BALTIMORE MD 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death dent's Name (First, Middle, Last) Пау **Physician** /Medical 4c. County of Death Name (If not institution, give street and number) **Examiner** edica N/AIf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Rhode Island If Under 1 Year 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2√2 F 52 231-94-5430 March 18, 1958 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 28a-f show ns 23a or 28a-f shor 1 ☐ Yes 2 ☑ No Directo Crofton Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21114 2018 Aberdeen Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates Specify Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Midical Elementary/Secondary (0-12) College (1-4or 5+) L.P.N. Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick M. Finn ဂ Sarah F. Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 Aberdeen Drive, Crofton, Leland Linder, Husband Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition ŏ 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Metro Crematory, Inc. 6/24/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23h. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) been signed by the should be detached Tyes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ 📆 o 24a. Was an certificate has tirector, page 2 s autopsy 2 0 2 **10**0 1 ☐ Yes or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕡 1 npatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 31. Date filed (Month. Day. Year

DHMH 17 Rev 1/2001

State

Registrar

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	Dharia		1. Decedent's Name (First, Midd	le, Last)				2. Date of Deat Month			3. Time of Death		
	Physic /Medi		John Michael	Lawrence			JU			Year 2010	218 PM		
	Exami		4a. Facility Name (If not institution	n, give street and numbe	r)	4b. City, Town, or	Location of Deat		4c. County				
-			Good Samarat				ltimore						
п	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ☐ F	Age (In yrs. last birtho	Months Dave	If Under 24 Hrs Hours Min.	<ul> <li>8. Date of Birth (Month, Day,</li> </ul>	Year)	9. Birthpla Count	ace (State or Foreign ry)		
Ь	Director		215-42-5914 Usual Residence of Decedent	X .		January	8,1944	Ma:	ryland				
	/land iow		10a. State 10b. County		10c. City, Town o	r Location				10	d. Inside City Limits		
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	or 28g	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of	What Count	ry?		
	th wit	a [	900 Dellwood	Orive		2104	47		USA	USA			
	r dea	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	Was Decedent of Hi     If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		ce - America			
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Everniner must be notified at	ğ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 Tyes 2 T	No	1 □ Yes 2 No	Specify:	o Alcan, etc.)	Specify	ck, White, et v: W]	hite		
5-	72 h	Completed	15. Deceder (Specify only highe	t's Education st grade completed)	16a. De	ecedent's Usual Occupa	ation	king	16b. Kind of B	usiness/Indu	ustry		
121	within fene. than "	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	ive kind of work done a e. DO NOT use retired	)	Kiriy					
2	filed w Hygie ther t		12		2 D	esign Engir			Engine				
anc	12 should be fi h and Mental I 7 Is marked ot raumatic ever	Be	17. Father's Name (First, Middle, Maurice Lawren	,				ne <i>(First, Middle, M</i> e <b>Pri</b> este		ne)			
Z	hould id Me mark matic	은	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
, Ma	1 and 2 sho Health and I em 27 Is ma other trauma		Tony Battaglia	Cousin		9305 Sandra	a Park R				. 21128		
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other tone.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S			sposition (Name of rematory or other place of Faith	6-22		Balto.		n, State		
Ball	permit Depart Import any in		21. Signature of Funeral Service	Licensee		22. Name and Addres	50.	himunek F			0.6		
			23a Part 1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do not	9705 Be	lair Rd. g, such as cardiad	Nottingh or respiratory arre	am, Md st,	212	36 Approximate nterval Between		
4	Physician	6.4	Immediate Cause (Final disease or condition	a. 5 TMGG						1 8	Onset and Death		
1	/Medical		resulting in death)		s a consequence of):	en invo				-	1 4/1.		
	Examiner		Sequentially list conditions	b									
	ed sit	Examiner	Sequentially list conditions, if any, leading to the cause. Enter Underlying Cause (Disease or injury that initiated exerts.	Due to (or as	a cousednesses of).					- 1			
	xecut and I-tran	хаш	that initiated events resulting in death) Last	c									
68760,	be e iician burla	a E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as	a consequence of):					- 1			
587	ficate phys s the	Medical		d	-								
×	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy				201 0				
Вох	death e atte	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Dai	e of delivery nth D	y lay Year		
P. 0.	t the	hys	9 Unknown	9 ☐ Unknown									
ę,	s tha gned e det	by P	Part II. Other significant condition	ns contributing to death b	out not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use conti	ribute to the	cause of death?		
ğ	w require s been sig should b	edt	Z01D					1 Yes	2 □ No	3 ☐ Probal	bly 4 ☐ Unknown		
ည္မ	aw re as be 2 sho	Completed						24a. Was an	24b. \	Vere autops	sy findings available		
œ i	The The ate his	E						autopsy perform	ede d	prior to comp death?	oletion of cause of		
Ħ.	artifica	Be	25. Was case referred to medical				26. Place of Deat	1 ∐Yes 2) th (Check only one)		☐Yes 2	∐No		
<u> </u>	Physician: The law r this certificate has t ral director, page 2 sl		examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 ☐ ER/Outpat	Other		ome 5 🗆 Resider		er (Specify)			
ב ב	ng P	ä	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury 28b. Time			28d. Describe how	_				
Sio	tendleath.	cati	2 Accident investig	ation			es 2 □No						
Division of Vital Records,	The foot man of Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Phours after death.  Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Place of Inj	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural F	Route Number,		
	vithin 24 hou vithin 24 hou to the Funer Completely fill	edical	29a. Certifier 1 Certifyin  (Check only one) 2 Medical 1	<b>Physician:</b> To the best examiner: On the basis of and manner st	or examination and/or	ath occurred at the time investigation, in my opi	e, date and place inion, death occui	, and due to the car rred at the time, dat	use(s) and ma e and place, a	unner as sta and due to th	ted. ne cause(s)		
ř	within 2 To the C		29b. Signature and title of certifier	111111		29c. License	_		d. Date signed				
			Immign Il	(INNAN)		D15	135	3	mus	1613	2010		
			30. Name and address of person of DEMOUNE 50	who completed cause of o	leath (Item 23a) (Typ	Sall	ND NA	12001	15 112	2 2	1239		
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1010000000	()/0	V111111/L	61,017		1		
	Registra		IIINS	4 2010	wer is.	parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 9: 2010 12:15 A M Medical e (if not institution, give street and number, **Examiner** Town, or Location of Death County of Death Battimore limonium last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 XM 2 🗆 F Hours Director 10b. County 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits more 1 XYes 2 □ No 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working his DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secorday (0-12) College (1-4 or 5+) Be ner's Name (First, Middle, Last, ပ should be 1 Informant's Name/Relationship (Tvd Page 1 and 2 . Denison Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery Cematply or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, injury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ END STAGE RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No After this certificate 2 🗆 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number person who completed cause of death (Item 23a) (Type, Print) 30. Name and a JONES, 2300 DULANEY VALLEY JACKIE RD. TIMONIUM. MD 21093 State Registrar

a.m.

2010

19,

			For	State	of Maryla	ind / Depa	artment of H	lealth an	d Mental Hy	giene		
			State Registrar			Cei	rtificate of I	Death		Reg. No.	2010	19780
	Physici	an	1. Decedent's Name (First, Middle						Date of De     Month		Year	3. Time of Death
	/Medio	al	Florence	K. Leb					June 2	<u> </u>		7:35 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution		iumber)		4b. City, Town, or		4c. Co	ounty of Death		
4"	Funeral		6806 Barnett R	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	ltimore If Under 24 F		th	Baltir 9. Birth	place (State or Foreign
	Director		217-20-5844	1□M 2 <b>X</b> F		83 Yrs.	Months Days	Hours M	Hrs. 8. Date of Bir (Month, Da March	iy, <i>Year)</i> 18. 19	Cou	ryland
	pu ,		Usual Residence of Decedent									
	aryla shov	č	10a. State 10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Director	MD Ba1	timore		Balt	imore 10f. Zip Code			10- 0:::		
	with sa or		6806 Barnett	Pood			21239	,		iug. Citizer	n of What Cou	
	ms 2;	Funeral	11. Marital Status	12. Was Dec	cedent Ever in l	U.S. 13. V	Vas Decedent of H	ispanic Origin?	? (Specify Yes or No	- 14.	. Race - Ameri	
٥	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, I'm McTotal Eva cili writinust be notified at		1 ☐ Never Married 2 💢 Marr		2 <b>X</b> No	1	f Yes, specify Cuba	ın, Mexican, Pu	uerto Ricán, etc.)		Black, White,	etc.
5-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	Dates:		I□Yes 2XINo	Specify:		Sp	pecify: Whi	ite
<u>.</u>	"natu	Completed	15. Decedent (Specify only highes	's Education t grade completed	)	16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of v	working	16b. Kind	of Business/Ir	dustry
7	withir ene. than	dmc	Elementary/Secondary (0-12)	College (	(1-4or 5+)		nistrativ			1.1.		Electric
D	filed Hygi other ent, I		17. Father's Name (First, Middle,	Last)		Adıııı	nistiativ		Name (First, Middle,			Flectric
yland	3.2 should be filed within 72. In and Mental Hygiene. 7 is marked other than "n traumatic event, In Men	To Be	Stanlislaus Ku	lis					line Posp		,	
Mary	shou and N s ma		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailin	g Address (Street a	and Number or	Rural Route Number	er, City or To	own, State, Zij	o Code)
e, E	and 2 ealth n 27 i		Paul Lebert/Hu	sband		6806	Barnett	Road :	Baltimore	, MD 2	21239	
9	ges 1 t of H If iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from	20b.	Place of Dispos cemetery, crem	sition (Name of natory or other plac	e) .Tiir	ne 26,	20c. Locat	tion - City or To	own, State
Daltimol	t. Pag tmen tant: ijury		4 □ Donation 5 □ Other (Sp	pecify)			Cemetery	2	010		altimor	
a D	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Fundral Service I		<b>\</b>	Lei	Name and Addres	s of Facility	me of Dul	aney V	Valley,	Inc.
			-/ · · ·	ichael J.		e  10	w. Pador	ila koa	a limoniu	m, MD	21093	
	Neve (e (e e V		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final			atii. Do not ente	er the mode of dyin	g, such as care	ulac or respiratory at	rest,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Seps	SÍS o (or as a conse	orience of):					_	Days
and a	Examiner				rene	quence oi).						Weeks
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	U	(or as a conse	quence of):						Weeks
5	ecute and transi	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	C			ar Diseas	e				Years
8	fficate be executed g physician and s the burial-transit	<u>E</u>	resulting in death) cast	Due to	Due to (or as a consequence of):							
00/00	ficate physics the l	edical		d								***
<u> </u>	eath certifi attending for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pregr	nancy				224	I. Date of deliv	977
ַ הַ	Attendum Prystcian: The law requires that the death certing that the death certine defore. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	in the past 12 months?	1 ☐ Live 4 ☐ Preg	birth 2 Fet gnant at time of	tal death 3 🗆	Ectopic pregnancy Other <i>(specify)</i>	′		230	Month	Day Year
	at the de by the a stached	hys	9 ☐ Unknown	9 ☐ Unkı	nown							
'n	res tha signed l	P P	Part II. Other significant condition			sulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
5	w require been si should t		End Stage Kidn	ey Diseas	se				_ 1 🕱 Y	es 2□N	No 3□ Prol	bably 4 ☐ Unknown
<u>د</u> . يا	law r las be	Completed	Coronary Arter	y Disease	2				24a. Was autop			ppsy findings available impletion of cause of
, i	cate l	ပ္ပ							perfor 1 □ Yes	med?	death? 1 □ Yes	•
	sician: The la certificate ha irector, page	Be	25. Was case referred to medical examiner?	Hospital:			T au		Death (Check only o	ne)		
5 2	Phys r this ral dir	6	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date		ER/Outpatient		4 Li Nursing	g Home 5 Resid			fy)
5	th. : After : funer	tiol	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mor	nth, Day, Year)	Injury	28c. Injury Work	/ai ? ⁄es 2 □ No	28d. Describe h	ow injury oc	ccurred	
2	Atter	iţica	3 ☐ Suicide 6 ☐ Could not determine	ot be 28e. Place	e of Injury - At h	່ ກຸວກຸາe, farm, stre	et, factory, office	_	28f. Location (S	treet and N	lumber or Rura	al Route Number,
5	ral or s afte al Dir ed in	Certification:	4   Homicide	build	ling, etc. (Spec	ity)			City or Tow	n, State)		
į	lo the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	ledical	Check only 2   Medical E	Physician: To the	e best of my kn	owledge, death	occurred at the time	ne, date and pla	ace, and due to the	cause(s) an	id manner as s	stated.
1	thin 2	Medi	29b. Signature and tille of certifier	and man	nner stated.							
ŀ	8 4 ₹. ⊼	-	200. Signature and the of certifier	10.0	W		29c. License				igned (Month, 23 × 2	
•		-	30. Name and address of person w		/	m 23a\ /T D		10		- UV -	070	-10
	10		Richard A. O'Ma					e 311	Towson, N	m 212	204	
	Stat	е	31. Date filed (Month, Day, Year)		Registrar's Signa							
	Registra	7	JUN Z 4 ZUIU	Lucy !	Jul . 169 6	Marie and						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Month 06 MOHLER 20:05 M SAIL OR Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY BENERAL COLUMBIA, MD HOWARD COUNTY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 9. 1 9. Birthplace (State or Foreign **Funeral** Virginia 1 🔀 M 2 □ F 66 1943 Director 223-58-1078 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filled within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? Funeral 5410 Lightning View Road United States 21045 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1960-Black, White, etc. 9 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1964 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physicist/Inventor Biomedical Engineering traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Andrew permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Mohler Dollie Mae Truslow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleve C. Mohler, Wife 5410 Lightning View Road, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/24/2010 Baltimore, Maryland 21. Signatura of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical þ Completed Be 10

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this filled in by the funeral

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funeral Director: Al

Certificate:

Medical

Emlie J. B. Calvello 31. Date filed (Month, Day, Year)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves 2   No 9   Unknown   Vestion   Vest											
Part II. Other significant conditions	contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?							
Coronary artery disease  1 Yes 2 No 3 Probably 4 Unknown  Pericardial effusion  24a. Was an autopsy findings available prior to completion of cause of											
pericardia	1 effusion		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No							
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)								
1 Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Res									
27. Manner of Death  1 ★ Natural 5 ☐ Pending 2 ☐ Accident Investigati	28a. Date of injury (Month, Day, Year)  28b. Time of injury  N	28c. Injury at work?	8d. Describe how inju								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 L Medical Exar	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier	-	29c. License number	29d. D	ate signed (Month, Day, Year)							

D69061

06/18/2010

21218

DHMH 17 Rev 7/2009

State Registrar CALVELLO MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The die of B. Colvello 246 Kentucky Ave. Boltsmore, MD

32. Registrar's Signature

			For State	State of Maryla				lental Hyg	iene	10783
		-	Registrar  1. Decedent's Name (First, Middle, Las.	t)	Cer	tificate of Dea	atn 	2. Date of Deat	eg. No.	1 3 1 0 0
	Physicia Medio		Kenneth	Minkle				Month	20 20 Year	3. Time of Death  OG38 AM
	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or Loc	cation of Death		4c. County of Dea	
			University of Mai				ultimor		N/A	
н	Funeral Director		5. Social Security Number 6. Se 216-72-2606	X M 2 $\square$ F 7. Age (In yrs.	14-		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Aug. 29	Year) 9. Bi	irthplace (State or Foreign ountry)  Maryland
			Usual Residence of Decedent					Aug. 29	,1930 1	Maryranu
	ryland -f sho ied at	ctor	10a. State 10b. County N/A	10c. C	ity, Town or Loc	altimore				10d. Inside City Limits
	or 28a	Dire	10e, Street and Number			10f. Zip Code		1.	10g. Citizen of What C	1 X Yes 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	2622 Cole Street			212	223		United S	
	death items	Fun	11. Marital Status	12. Was Decedent Ever in U Armed ForcesX		/as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spector)	cify Yes or No-	14. Race - Am	
36	al", or	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		☐ Yes 2 🕅 No S		,	Black, Whi Specify: W	hite
9-0	hours natura lical E	Completed	15. Decedent's Ed			ent's Usual Occupation			16b. Kind of Business	s Industry
21.	hin 72 ne. than " e Mec	omp	(Specify only highest gra-	College (1-4 or 5+)	life. DC	ind of work done during NOT use retired)	g most of workir	ng l		
2	ed with	BeC	17. Father's Name (First, Middle, Last)	<del></del>	Lá	indscaper	NA-Ab-ula Na	/First Middle A	Landscap	ing
auc	be file ental l rked o ic eve	임	George A. Min	kle		18.		sita Go	faiden Surname) Mez	
ary	hould and M is mar		19a. Informant's Name/Relationship (Ty)		19b. Mailin	g Address (Street and I	Number or Rural	Route Number,	City or Town, State, Z	ip Code)
Σ	nd 2 s lealth a m 27 i		Rosita Minkle -	Mother	2622	Cole Stre	et, Bal	timore,	MD 21223	
Baltimore, Maryland 21215-0036	ge 1a nt of H :: If ite or otl		20a. Method of Disposition  1	Removal from State	- The second sec	atory or other place)	D	ate	20c. Location - City o	r Town, State
ltir.	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify			Crematory Name and Address of	June	24,2010		rnie, MD
Ba	permir Depar Impor any ir		( All link	Will the		328 Sulphur				
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the dea						Approximate Interval Between
ŧ	nysician/:	11	Immediate Cause (Final disease or condition	Metastatic	Uro	thelial	Conce	P		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	cuted nd ransit	Examiner	Cause (Disease or linjury that initiated events	c						
	icate be executed physician and s the burial-transit	alE	resulting in death) Last	Due to (or as a consec	quence of):					
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89	certifi anding use as	M/M	Zob. Was decedent pregnant	3c. If yes, outcome of pregn		F-4			23d. Date of de	elivery
Ĝ.	death he atte ed for	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	Day Year
o i	at the d by tl letach	Phy	9 ☐ Unknown  Part II. Other significant conditions co		sulting in the ur	derlying cause given in	n Part I.	23e Did tob	acco use contribute to	o the cause of death?
Records, P.O. Box 68	ires th signe d be c					3 3 7 3 7 7		1 🗆 Ye	\u00e4	Probably 4 🗆 Unknown
ord	v reques s beer s shou	Completed						24a. Was ar		utopsy findings available
Sec.	The lay	mo.						autops perform 1  Yes 2	ned? death?	completion of cause of
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<u> </u>	Physic this c	욘	1 ☐ Yes 2 No F 27. Manner of Death	lospital: 1 Inpatient 2   28a. Date of injury	ER/Outpatient 28b. Time of				nce 6 Other (Spec	pify)
Division of Vital	th. After funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury at work?  M 1 Yes	2 🗆 No	8d. Describe ho	w injury occurred	
ISIO	er dea ector by the	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, stree		2		eet and Number or Ru	ıral Route Number,
Cause (Disease or injury tarificated events tresulting in death) Last  C. Due to (or as a consequence of):  d										
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
÷	Nithin To the compl		29b. Signature and title of certifier	PARESTONER TO THE DEST OF IT	ly ki lowaega, ek	29c. License num			9d. Date signed (Mont	
			angel to CCUCOG	aus, MD		1710112	25 LeO		6/20	12010
			30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, Pr	<del></del>	22	Sovm	Greene 1	St
	Stat		31. Date filed (Month, Day, Year)	32. Re trar's Signa	ature -		рa	ttimore	E, My 21	CO1
	Stat Registra	-	JUN 2 4 2		1. 1	backer				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:12 Patricia Anne Mondshour 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST ASNES HOSP, tal BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Jun. | 27, Year | 952 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Maryland 57 Yrs. Director 215-60-0501 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified 28a-f 1 ☐ Yes 2 X No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a **Funeral** 132 A Hazel Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 'natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important; If item 27 is marked other t any injury or other traumatic event, the once. Assembly Line Worker Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Hart Margaret Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 132 A Hazel Avenue, Baltimore, MD 21227 James A. Mondshour - Husband Baltimore, Method of Disposition 20b. Place of Disposition (Name of G1en Have major we of Part of the place of Mellio F1a1 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6-24-2010 Glen Burnie, MD ark uneral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ CHRONIC UBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events the attending physician and Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ISCHEMIC CARDIOMYOPATHY Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 ☐ Yes 2 ☐ No Yes Division of Vital 0205ho4 the Hospital or Attending Physician: 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DU051365 ST. AGNES HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARLES AVENUE 900 31. Date filed (Month, Day, Year) 32. Registra s Signature State arke

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SR. JOHN Η. **MEYERS** ID: SOA M スのの Medical Eacility Name (if not institution give street and number) Examiner County of Death 8. Date of Birth (Month, Day, Year Ian 3 1924 7. Age (In vrs. If Unde 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F 216-16-9446 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 7536 Brightwater Beach Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Yes, Give 2 No 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygene. Important If frem 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ó Quality Control Manager Domino Sugar Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should be Charles Willum Meyers **Ethel** Dalbarn Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna M. Smith Meyers (Wife) 7536 Brightwater Beach Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Crownsville VA Cemetery June 23, 2010 Crownsville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician/Medical Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burfal-transi that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**O 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) npatient 2 ER/Outpatient 3 DOA 27. Manner of D ath 1 N Natural 2 D Accident 3 Suicide 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 OX of person who completed cause of death (Item 23%) (Type, Print) MP. 21061 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June -23, 2010 Physician 6:00 AM Marie Virginia Munzner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Months Maryland 1 ☐ M 2 😡 F 212-03-1221 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore Director MD 1 ∐Yes 2X No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21234 USA Funeral 7836 Westmoreland Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify: 2 Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Sophia Waltjen Frederick Henry Adam Nily 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7836 Westmoreland Avenue-Parkville, MD 21234 Kenneth Munzner-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Parkwood Cemetery June 26,2010 Parkville, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Svrs. 8800 Harford Road-Parkville, Maryland 21234 in 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fiate Cause (Final EREBRO THEROSCLEROTIC VASCULAR dise se or condition reliting in death) Due to (or as a consequence of): Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) 9 TUnknown Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 TEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed YPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed ELL BASAL 2/2 No 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner and burial-trar Division of Vital Records, P.O. Box 68760. the

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

I Hygiene.

Pages 1 and 2 should be filed and the filed and Mental Hyginers of Health and Mental Hygint: If item 27 is marked other

permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is marl any injury or other traumati

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician the signed by the peen has certificate this funeral After

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Funeral Director: within 2

> State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

sueen

3 ☐ Suicide

29a. Certifier

ca

4 Homicide

(Check only one)

29b. Signature and title of certifier

IASNEEM

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AVE, BAUTO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2835

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MI

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month June 2010 Vincent Рм Gilbert 6:40 Ottaviano Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9th Street Anne Arundel Pasadena 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) August 2. 1 XM 2 □ F Director 219-40-5767 66 1943 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🛣 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9th Street 21122 U.S.A. 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry I Hygiene. ₩oodworkerecraftsman Elementary/Seconday (0-12) College (1-4 or 5+) 8 N/A Boat Builder Naval Academy permit. Page 1 and 2 should be filled wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ottaviano Anthony Anna Mae Lowerv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3578 Brickwall Lane Pasadena, Maryland 21122 Leslie D. Ottaviano (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/22/2010 Cremation Atlantic Glen Burnie, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility Cully-Polyniak Funeral Home, P.A. 204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or se a consequence of): Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ☐ Live Birth ∠ ☐ 1900 9-1 ☐ Pregnant at time of death ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 s autopsy death? certificate 2 1 No 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4304 MTN. RD. GAR6 and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 43A M Physician/ Medical 4b City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** GOMERY Pring MONT S t05P DILVER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F 95 Days Hours Douth -88-909 Director Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location **Funeral Director** nea 1 Yes 2 No 10f. Zip Code . Street and N 10g, Citizen of What Country? 209 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Sesonday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ UN KNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RNNY eun G 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State -2010 ملك 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Line 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one cause on each limit and the cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and mannered filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 🖸 9 ☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No. 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Natural Accide 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License numbe

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

mpleted cause of death (Item 23a) (Type, Print)

32. Registr

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert People		I- For State	ate of Maryl		artment of rtificate of		and	Menta	al Hyg		201 g. No.	0	19789
Physicia		Registrar 1. Decedent's Name (First, Midd	e,Last)						2.	Date of Deat		3	3. Time of Death
<sup>⊮</sup> ≏dical Exami	ner	ROBERT	PEOPLE .							June 21, 2	010		0954 hrs
		4a. Facility Name (if not institution	n, give street and n	iumber)	4	b. City, Tow	-	cation of	Death		4c. County of	Death	
		Sinaí Hospital				Baltimo			200		N/A	O Diah	alass (State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.	8. Date of Birt	h(MM/DD/YYYY)	Foreign	MARYLAND
Director		217-68-2278	1 XX 2 F		52 Yrs.	Monare	Dayo	1,04.0		06/25	/1957	Cour	ntry)
*		Usual Residence of Decedent		Idon City	, Town or Location							- 1.	Od. Inside City Limits
w any		10a, State 10b. County		Toc. City								- 1	1 X Yes 2 No
Aaryland 28a-f show 1 at once.	힐	MARYLAND N/	<u>'A</u>		BALTIMO	ORE 10f. Zip Co	do				ng. Citizen of Wha	t Counti	
Mary r 28a ed at	Director	10e. Street and Number				TOI. ZIP CC				"			,.
th the Maryland 23a or 28a-f sho notified at once.		807 LENTON A		PT B.	10 142 Wee	December	212		n2 / Sno	cify Yes or No-	U.S		an Indian, Black,
th wi	Funeral	11. Marital Status 1 X Never Married 2 M				s, specify C					White, etc.		
er dez			1 Yes		1	Yes 2 X	No	specify:			Specify:	BLAC	CK CK
ırs aft ural'	<u>a</u>	15. Decedent's Education (Spe	or Dates:		16a. Decedent	's Usual Oc	cupatio	n (Give ki			16b. Kind of Busi		
2 hou	je	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during mo	st of workin	g life. D	OO NOT u	ise retire	d)			
)36 thin 7 re.	Completed	12th grade				CONTR	RACT	OR			SE	LF	
215-0036 be filed within 72 hours a nital Hygiene. rked other than "natura rent the Medical Examin	S	17. Father's Name (First, Middle	, Last)				18	3. Mother's	Name (F	First, Middle, N	Maiden Surname)		
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than a event, the Medica	å		PLE SR.							SUMMER			7. 0. 1.)
21 nould is ma rite ev	P	19a. Informant's Name/Relations	ship (Type, Print)		1,1110	•					ber, City or Town		
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene.  Ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	J	Michael A. Peo	ple/Son	20h	4710 Place of Disposi					<u>altimo</u> Date	re Md.	212 City or T	206 own, State
or He, of He If ite		1 Burial 2 X Crematio	n 3 Removal		crematory or oth		0, 00					•	
imc Page ment tant: or of		4 Donation 5 Other S		ME	TRO CREI				06-2	3-10	BALTIMO	RE,	MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumantic event, the Medic		21. Sonature of Funeral Service	Ligensee		WI	ame and Ad LLIAM	C B	ROWN	COM	MUNITY	FUNERAL	HON	ME P.A.
	At the state of th										Approximate Interval		
Physician /Medical	1	failure. List only one cause	on each line.										Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):											
	L	Sequentially list conditions,	b		-6.								
	Examine	if any, leading to immediate cause. Enter Underlying Cause		a consequence	O().								
J. 2 2	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):	-							
P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	dical f	UNPENDED	d AMENDED	)		_							
60, ate be hysici e buri	Med	IF FEMALE:	23c. If yes	s, outcome of pre	egnancy						23d. Date of o	delivery	
587 ertifica ding p	sician/Me	23b. Was decedent pregnant in t past 12 months?		e birth	14.	al death	3	Ectopic	pregnan	су	Month	D	ay Year
OX ( ath ce attene	sici	1 Yes 2 No 9 Ur	denous -	gnant at time of o known	Jean 5 Oti	ner (Specif)	<i>"</i> )						
b. B. the de ched the	Phy	Part II. Other significant cond			resulting in the u	nderlying ca	ause giv	ven in Par	t I.	23e. Did to	obacco use contrib	ute to t	he cause of death?
P.C es that	δ									1 Yes	s 2 No 3	Proba	ably 4 🗸 Unknown
ds, equire een si ould t	Completed			<u></u>						24a. Was			opsy findings available ompletion of cause of
COF law r has b	)du										rmed? de	eath?	·
Re : The ficate f, pag	ပ္ပ	25. Was case referred to medic	al I			26	Place o	of Death (	Check or		2 140 1	V 10.	2 10
ital sician s cert irecto	Be	examiner?	Hospital: 1	Inpatient 2	/ ER/Outpatient		16	other4		Home 5	Residence 6	Other:	
Division of Vital Records, P.O. Box 68760 as or Attending Physician: The law requires that the death certificate be refred earth. After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the bu	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	ite of Injury	28b. Time of I		c. Injury	at Work	? [2	28d. Describe	how injury occurre	ed	
on on anding ath.	tion		nding	nth, Day,Year)			1 Ye	es 2	No				
2 Accident Investigation 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural For Town, State)										al Route Number, City			
Divisior ospital or Attend hours after death uneral Director:	Month, Day, Year)  1 V Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide (Specify)  1 V Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route Number, or Town, State)												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funest Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying I Cone) 2 Medical Ex	Physician: To the taminer: On the bas	est of my knowle is of examination	edge, death occur and/or investigat	red at the ti ion, in my o	me, dat pinion,	e and pla death occ	ce, and courred at	due to the caus the time, date	se(s) and manner and place, and d	as state ue to the	ed. e cause(s)
Tot with Totl	Medical	29b. Signature and title of certif	and manne					number			29d. Date signe		
	_	1/1///	//				O.C.N	1.E.			June 22, 20	10	
\		30. Name and address of person	n who completed c	ause of eath (Ite	em 23a)		_						
1		Melissa Brassell, MD	Assistant N	Medical Exam	niner 111 F	enn Stre	et, Ba	altimore	e, MD 2	21201			
S	tate	31. Date of M (6) 74, 2017	Denes 32	Registre s Sign	will								
Regis	trar		/										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Price JUNE 4.054 M Marv Medical 2010 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore Caton Manor Nursing Home Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Days Hours (Manth, Oay Year) 7 Country) 93 MD Director 212-14-8235 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b County 10c City Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director NA MD Baltimore TX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 Wilkens Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 🛛 No Specify: American 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 6th Grade College (1-4 or 5+) NA Domestic various jobs permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important; If item 27 is marked other t any injury or other traumatic event, th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Turner Turner Grace Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $212\overline{002}$ 19a. Informant's Name/Relationship (Type, Print) 10 N. Calvert Street 3rd. Fl. Suite #300 Freida Jones-Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 06-24-10 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem. Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenser 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death FAILURE Physician, disease or condition resulting in death) FEW W BOK Medical Due to (or as a consequence of): Examiner FEW YRS Sequentially list conditions, if any reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 XNo 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗷 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 KNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending after death.

Director: Aff 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Precitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MD JUNE 23, 2010 Doc 62634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar MATEEN

31. Date filed (Month, Day, Year)

HICKURY RIDGE

COLUMBIA

10796

32. Registrar's Signature

Awm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Please Type or Print in Bia State of Maryland / State Per Verb., 8 Registrar	Department of Health and N	Mental Hygiene	2010 19791
		1	State Registrar	Certificate of Death	Reg. No.	3. Time of Death
	Dhusisian		Decedent's Name (First, Middle, Last)		Month Da	
	Physiciar Medica		Veronica Maria Pittman  . Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1111111	c. County of Death
	Examine		3813 Lewin Avenue	Baltimore		N/A
	Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) May 5	9. Birthplace (State or Foreign Country).  956 Maryland
	Director		220-64-7646		I May 31	10d. Inside City Limits
	show dat	- 1-	Da. State 10b. County 10c. City, To	own or Location ltimore		1X Yes 2 □ No
	Maryl 28a-f otifie	.⊆ L	Marylanu 1771	10f. Zip Code	10g. C	Citizen of What Country?
	ith the 23a or st be r	ral	De, Street and Number 5437 Force Road	21 20 6		USA
	ems?	in I	1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	fter de ", or it amine	ठ	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2x No Specify:		SpecifyBlack
8	ours a atural cal Ex	Completed	15 Decedent's Education	16a. Decedent's Usual Occupation (Give kind of work done during most of wo		Kind of Business Industry Ltimore City
215	n 72 h e. lan "n Medi	dmc	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired) tationary Enginee:	E4.	olic Schools
21	d withi lygiene ther th	1	7. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maide	n Sumame)
and	be file ental H ked of c ever	70 E	Ponald Taylor		Yarrell	
Maryland 21215-0036	nould ind Me s mari		19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R 1007 Reverdy Road	ural Route Number, City  Raltimore	or Town, State, Zip Code) e. Maryland 21212
Ž	nd 2 sh ealth a nn 27 ii			A This is a Market of	Date 20c.	Location - City or Town, State
ore	ge 1 and the strong of or other strong or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Nathe of netery, crematory or other place)  1 Lawn Cemetery  6/1	9/10 Wo	odlawn,Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 20a or 28a-f show important: If item 27 is marked other than "matical Examiner must be notified at once.		4 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	20 Name and Address of Facility 1-	atman-Har	ris FuneralHome
Ва	Depi Impo		Samuel Kinger	5240 Reistersto	wn Rd Bal	timore, MD 21215
		-	23a. Part : Enter the disease, or complications that caused the death. shock, or heart failufe. List only one cause on each line.	Do not enter the mode of dying, such as cardia	C//C	Interval Between Onset and Death
-	Physician/		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the condition of the condi	na, soft 113	340	Jan.
Secretary.	Medical Examiner		Due to for some days			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):		
	executed an and rial-transit	Examiner	Cause (Disease or iinjury that initiated events csulting in death) Last C. Due to (or as a consequence of the consequence of th	ence of):		
_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	-e	d.			
Box 68760	certificate be nding physici use as the bu	Physician/Medic				23d. Date of delivery
89 ×	n certii tendin	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal	death 3 L Ectopic pregnancy		Month Day Year
- 0	e deatl the att hed fo	ysici	1  Yes 2 No 9 Unknown			the second of death?
106 - 20 sords, P.O.	requires that the been signed by the should be detach	by Ph	Part II. Other significant conditions contributing to death but not resu	ilting in the underlying cause given in Part I.	1	co use contribute to the cause of death?  2 □ No 3 □ Probably 4 □ Unknown
S.	juires t an sign uld be	ed b			24a. Was an	24b Were autopsy findings available
€.	law rec has bee	Completed			autopsy performer	prior to completion of cause of death?  No 1  Yes 2  No
Be	The lacate h		The second to modify	26. Place of Death (C	1 ☐ Yes 2/ Check only one)	
ital,	<b>nysician:</b> The law nis certificate has b I director, page 2 s	Be	25. Was case referred to medical examiner?  1 Yes 2 No 1 Inpatient 2	ER/Outpatient 3 DOA Other: 4 Nursin		Sister's ce 6 XOther (Specific Residence
of V	g Phys er this eral di	بة: 5		28b. Time of injury at work?	28d. Describe how	injury occurred
U	eath. or: Aft	Certificate:	5 Accident Investigation	M 1 ☐ Yes 2 ☐ No me, farm, street, factory, office	28f. Location (Street	et and Number or Rural Route Number,
Division of Vital Rec	or Att after d Direct in by 1	Cert	4 Homicide determined building, etc. (Specify,	)	City or Town, S	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	edge, death occured at the time, date and place n and/or investigation, in my opinion, death occur	ce, and due to the cause red at the time, date and I	(s) and manner as stated.  place, and due to the cause(s) and manner stated
	the Ho iin 24 I the Fu	Med	only one) 3 Certifying Nurse Practioner: to the best of my	y knowledge, death occarred at the		
_	To t To 1		29b. Signature and fitle of certifie	100562	39 Ju	INE, 11,2010
			30. Name and address of person who completed cause of geath (Item	1 23a) (Type, Print)	DRIOL H	UNE, 17, 2010 UNE, 17, 2010
4)			VEROMICO EPSTEI		ivida All	
\ V	9	tate	31. Date filed (Month, Day, Year) 3. Registrar's Signa	" have		

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald E. Pfeil Jr. 12:450 2010 Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 75 Shawgo Court If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Hours (Month, Day, Year) 216-68-2588 **Director** 55 195 MD Dec.14 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Middle River MD 1 Yes X No 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21220 USA 75 Shawgo Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Army <u>12th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Menta Important if item 27 is marked any injury or other traums in once. Donald E. Pfeil Sr. Frances Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Orchard Beach MD 7918 Chesapeake Drive Philip M. Pfeil /son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 6/25/10 Baltimore MD Stanislaus 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fundal Servic Lice se 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the grath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FISTULIZING CROHNS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death a Unknown g Unknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RECENT SURGERY WITH RIGHT HEMICULECTUMY EXTENSIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown LYSIS OF ADMESIONS, COLUSTOMY TAKEDOWN, FORMATION . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ILEUSTOMY NEW OF 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending 24 hours a Funeral I

Registrar

(Check

only one)

29b. Signature and title of certifier

SUSAN L. BURG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERT, MD

32. Regis

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

COMPRENENSIX

29d. Date signed (Month, Day, Year)

23

2010

JUNE

CAREPRACTILE

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

5200 EASTERN AVE.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH,G906,8/6/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth OF WM ILLIP IAN 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours 1 M 2 F (Month, Day, Year) 01/01/1928 82 Marvland Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f shor 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1607 Cypress Street 21226 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 → Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygelee. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Schultz Mary Swodoba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Rose / Son 81 Old Jones Station Road Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State 06/24/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Holy Cross Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. aly 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ATHENOSCIENCE CUDISEAGE MERTENSIVE disease or condition Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hespice House 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Franticients to the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Franticients to the bast of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier Name and address of pelson who com ed cause of death (Item 23a) (Type, Print) ANNAPOUS MD 21401 NM m 445 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5&17 Per FH G908 10/29/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month, Year Physician dal 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Hombwool 16NGS 4 Birthplace (State or Foreign Country) If Under 1 7. Age (In yrs. last birthday) 5. S213 Security N4726618 **Funeral** 92 Yrs. Months Days 1 M 2 Director *3605* the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at 1 Tyes 2 No MI Director More 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 2121 6000 ma "natural", or items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 V6 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 10 Whi Baltimore, Maryland 21215-0036 1 Tyes Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "na any injury or other traument. Elementary/Sacondary (0-12) College (1/4or 5+) 'S 18. Mother's Name (First, Middle, Maiden Surname, 17. Eather's Name (First, Middle, Last) Be Irvin Mayes, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type\_Print) Guardi NON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Glen Burni 24/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service License 22. Name and Address of Facility +cights MI) 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE Milton **Physician** disease or condition resulting in death) DRONAMY /Medical Due to (or as a consequence of): Examiner KUDNO HINDMC Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 1 PENTENSION Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician VAWCON Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 □ Yes 2□ No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 25 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A death. 2 ☐ Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra s Signa State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Donald John Robinson, Sr. June 22 5:30 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Rosedale 139 Evering Avenue Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F **Director** 214-50-4363 61 December 9. Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Baltimore Rosedale 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21237 139 Evering Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 2 X No 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify "natural", 3 Widowed 4 X Divorced Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Auto Body Fender Technician Automotive 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Juanita Pearl Mallett Ordie Oden Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 Ottawa Avenue Baltimore, Maryland 21230 Mildred Robinson ex wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State June 27, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Bavview Crematory 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 10Coun Ph sician/ disease or condition resulting in death) WINS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine D e to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant a
9 Unknown Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify, Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 1 24 hours after death.
e Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the f only one) 29b. Signature and title of certifier ,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Robinson Year May 27, 2010 8:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5605 S. Marwood Boulevard Apt.331 Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye J**an** . 2 , 9. Birthplace (State or Foreign Country)
D. C. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛭 F Hours 77 579-48-3422 **Director** 1933 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d, Inside City Limits Directo Maryland Prince Georges Upper Marlboro 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5605 S. Marwood Boulevard S. A. Apt. 331 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 B1ack 1 Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Howard Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Craig Ethel Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Robinson (Son) 18 Van Buren Street, N.W. Washington, DC 20011 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 06/04/2010 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 7. H. Bacon Funeral Home, Inc. 47 14th Street, N.W. Washington, 21. Si nature veral Se 20010 disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death failure. List only one cau e on each line. Physician Medical **Examiner** Examine attending physician and for use as the burial-tran Physician/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s been signed by the should be detached has le 2 page certificate

Be Completed by မ Medical Certificate: within 24 hours after death

To the Funeral Director: completed filled in by the

disease or condition	a Advanced De	mentia							
resulting in death)	Due to (or as a conseq								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a conseq								
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	-						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	1 Live Birth 2 Fet	3c. If yes, outcome of pregnancy  1							
Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	2		use contribute to			
				•	4a. Was an autopsy performed? ☐ Yes 2 ▼ 1	death?	utopsy findin completion s 2 😾 No	of cause of	
25. Was case referred to medical			26. Place of Death (Chi	eck only c	one)				
examiner? 1  Yes 2 No	Hospital: 1  Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5	X Residence	6 ☐ Other (Spe	cify)		
27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred						_	
4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact y)	ory, office		ocation (Street a ity or Town, Stat	nd Number or Ru e)	ural Route No	ımber,	
(Check 2 Medical Exami	sician: To the best of my know ner: On the basis of examination to Practioner: To the best of m	on and/or investigation,	in my opinion, death occurred	d at the tin	ne, date and place	e, and due to the	cause(s) and	manner stated	
29b. Signature and title of certifier	M	2	9c. License number			ate signed (Mon			
	0 / 0		D0062885		Ju	ne 22,	2010		

Riverdale, Maryland 207

20737

6510 Kenilworth Ave.,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OW

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2010 **Physician** May 30, 10:15 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5605 Prince Georges S. Marwood Boulevard Apt. 331 Upper Marlboro 8. Date of Birth (Month, Day, Ye Sept. 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Year D. C. Min 1፟፟፟M 2□ F Sept. **Director** 578-40-7200 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov Maryland Prince Georges Upper Marlboro 1X Yes 2 □ No Director 10e\_Street and Number 5605 S. Marwood Boulevard 10f. Zip Code 10g. Citizen of What Country? Apt. 331 20772 U. S. A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1 −53
If Yes, Give 51−53
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ¹by. 1 ☐Yes 2 🛛 No Black Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tour Guide Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olin Robinson Susie Short ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) : If item 27 is or other tra 18 Van Buren Street, N. W. Washington, Dc 20011 Richard Robinson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti
once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Beltsville, Md. Chesapeake Crematory 06/04/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N. W. Washington, D. C. 20010 ease, or complications that caused the death. ure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 (er the shoot or heart Do not enter the mode of dying, such as cardiac or respiratory arrest, Imme at Caus Final dise or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) detached ss been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 40 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 N this Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Recidence 6 Other (Specify) funeral 28b. Time of Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. After Notural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 □ No s after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) To the Hospital within 24 hours a To the Funeral L Hospital 29a. Certifier Afying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dival Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and I anner stated. 29b. Signature and itle o 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Suite 1400

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylan		tificate of L			. No. 2010	19798	
	Physicia Medic		1. Decedent's Name (First, Middle, Last, VIOLET		SCHAFI	ER		2. Date of Death Month JUNE 2	2, 2010	3. Time of Death  1:45 PM	
وراق العمدة	Examin		4a. Facility Name (if not institution, give s				Location of Death		4c, County of Dea	'IMORE	
	Funeral Director		5. Social Security Number 6. Security Number 1 2 1 8 - 26 - 5 1 2 4		79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 10-13-	8. Date of Birth 9. Birthplace (\$\frac{(Month, Day, Year)}{10-13-1930} MARYL		
	aryland a-f show ified at	ector	Usual Residence of Decedent  10a. State 10b. County  MD BALT	TIMORE 10c. City	y, Town or Loc		SEDALE			10d. Inside City Limits 1 ☐ Yes 2 ☒No	
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 1218 HILLDALE I	ROAD		10f. Zip Code	21237	10ς	g. Citizen of What Co		
980	if filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 <b>X</b> Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates.	Н	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🔀 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:		
Baltimore, Maryland 21215-0036	vithin 72 hour iene. ir than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give I life. D	lent's Usual Occup dind of work done of NOT use retired) ACHER 'S	ation during most of work AID	B.	bb. Kind of Business ALTIMORE CONTROL		
land		To Be	17. Father's Name (First, Middle, Last)  J J N	MAGSAMEN			18. Mother's Nam LULA	e (First, Middle, Mai	den Surname) (HEIMBUC	CH)	
Mary	2 sho th an th is trau	4	19a. Informant's Name/Relationship (Typ. JEROME J SCHAFI		T		and Number or Rura		ty or Town, State, Zi DALE, MD		
more,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify,	Removal from State	emetery, cren	sition (Name of natory or other place FAI'IH CEME	<sup>(e)</sup> 6-2		c. Location - City or BALTIMOF	·	
Balti	22. Name and Address of FacilityCVACH / ROSEDALE 1211 CHESACO AVE ROSEDALE,									IERAL HOME 21237	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  STROWE										Approximate Interval Between Onset and Death DAUS	
	Medical Examiner	L	resulting in death)	Due to (or as a consequence PANCRE		CANCET	2			APRIL 2009	
	outed nd ransit	Examiner	Sequentially list conditions, if farw, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.								
09/	icate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a consequence).	Jence ot):						
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year	
, P.O.	es that the signed by i	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			o the cause of death?	
Division of Vital Records, P.O. Box	ne law requir ie has been s age 2 shoulc	Completed				1. 12		24a. Was an autopsy performe	24b. Were au prior to death?	ntopsy findings available completion of cause of	
tal	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	lospital:		Oth	ace of Death (Chec	k only one)			
ot	ing Phys ing Phys ineral dir	ate: To	1  Yes 2 No  27. Manner of Death  1 No Natural 5 Pending	1 Inpatient 2 2  28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	28c. Injur	y at k?	ome 5 Residence 28d. Describe how		HOSPICE	
Visior	or Attendi after death Director: A in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
Ω	Hospital 24 hours a Funeral I	Medical (	(Check 2 Medical Examin	ician: To the best of my knowler: On the basis of examination	and/or invest	igation, in my opini	on, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.	
-	To the within To the comple	Σ	only one) 3 Li Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the best of m		29c, Licens		290	use(s) and manner as I. Date signed (Mont TUNE 22	h, Day, Year)	
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type F	Print)					
	Sta Registr:		DANIENE- OCBER M 31. Date filed (Month, Day, Year)	32. Legistrar's Signa	ture A	HKLES S	1; SUII	T105 €	SHU MURE	, MO 61604	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day CHARLENE DENISE STEWART-WALKER Medical June 2010 • 50 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER FOR HOSPICE CARE BALTIMORE CO TOWSON 5. Social Security Number 6. Sex If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2XX Days Hours Min. JAN 28 MARY LAND **Director** 59 Yrs. 1951 213-52-7264 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2467 ETTING ST U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Contact Rep S S ADMIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ARTHUR STEWART HELEN LAWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trau Jada Mickie/Daughter 2467 ETTING STREET. BALTIMORE, MARYLAND 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) METRO CREMATORY 06-24-10 BALTIMORE, MARYLAND e of Fuyeral Service Lio LLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the shock, or heart failure Approximate List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) YERG Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other:

P.O. Box 68760 Division of Vital Records,

the burial-tran attending physician for use as the buria or Attending Physician: The law requires that the death certificate be Se nse the detached ģ s been signed to should be deta has certificate funeral director, this eral Director: After filled in by the funer death. after Hospital 24 hours To the Hosp within 24 hou To the Funer completed fil

27. Manner of Death

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and Mental Hygiene.

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Examiner

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the Maryland

within 72 hours after

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permit. Page

Baltimore, Maryland 21215-0036

	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury M	work? 1 ☐ Yes	2 🗆 No	200. 20001120	The Highly declared
	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		ory, office			(Street and Number or Rural Route Number, own, State)
	only one) 3 Certifying Nurse	r: Un the basis of examination	anczor investigation. I	n mv obinion, de	eath occurred a	at the time date	cause(s) and manner as stated.  and place, and due to the cause(s) and manner stated.  the cause(s) and manner as stated.
1	29b. Signature and title of certifier		/ 29	c. License num	nber		29d Date signed (Month, Day, Year)

28c. Injury at

lennaw. M 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print)

Year

4 Nursing Home 5 Residence

auson, MO

29d. Date signed (Month, Day, Year)

(eumasino

28a. Date of injury

6701 32. Registrar's Signature

State Registrar

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

10-04652	
Francine Curtis Scot	t
	1-1
	Re

ancine Curtis		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death	2010	19800
Physicia		Reg. No. Reg. No.	3	Time of Death
edical Exami		Francine Curtis Scott Month June 20, 2010	Year	1255 hrs
,			ounty of Death comico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/Months Days Hours Min. 06 19 194	9. Birthp Foreign Count	1.15
ow any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Upcation		0d. Inside City Limits
ith the Maryland 23a or 28a-f show any notified at once,	Director	MD Wicomico Salisbury  10e. Street and Number  530 Village Court  21801	of What Country	-
0036 within 72 hours after death with the Maryland jene. rer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Mexican Puerto Rican, etc.)	Race - America White, etc.	n Indian, Black,
2 hours after "natural", Examiner	ģ	3 Wildowed 4 Divorced in res, Give real or Dates: 11 Yes 2 No specify: Spec	ecify: BIG d of Business/Ind	ustry
1215-0036 felt ab filed within 72 hours after that Higten wastural", artect other than "natural", event, the Medical Examinet	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  Finance Clerk 3  Of	State	_
21215-0036 uld be filed within 77 Mental Hygiene. marked other than	Be Co		raw for	rd.
				ip Code) 21225
. 5 % 5 2		200. Head of Disposition 2 Demonstrate 2 Demonstrate Control of Disposition (Variation Control of Disposition Cont	ation - City or To	wn, State
Baltimore permit. Pages 1 a Department of He Important: If it		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licenses  22. Name and Address of Pacility Greene Funer	ndsor M	
m គួក្ខ≣់ផ្តា Physician		Vaughn C. Trelle 515/13abto. North Pice C	21229)	Approximate Interval
/ Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		Between Onset and Death
	L	Sequentially list conditions, b		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):		
executed ian and ial - transit				
	Wedic	UNPENDED AMENDED  IF FEMALE: 23d. D  23d. D	ate of delivery	
lecords, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physici age 2 should be detached for use as the buri	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Mo 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	onth Day	/ Year
i, P.O. Brires that the designed by the	by Ph			
cords, F law requires has been sign 2 should be g			24b. Were autor	psy findings available
DZ C .º [	Completed	autopsy performed?	death?	2 No
Vital   ysician: his certif director,	Be	25. Was case referred to medical 26. Place of Death (Check only one)	e 6 🗸 Other: S	cene
n of ing Ph	tion: To	O 1 Y 198 Z NO		
Division ital or Attencurs after death rear Director:	Certification:	Solution   Square   Investigation   Investigation   Square   Squar	Number or Rural	Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	129a (Jerriffler 1   2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		cause(s)
T in the second	Me		e signed (Month	i, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a)		
0		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		

State 31. Date filed (Mon Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c, County of Death IINORE TIMOR If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funera! Min (Month, Day, Year) 1 M 2 1 Director 219-40-981 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1√ Yes 2 No MD na Baltimore 10e. Street and Number 3806 Bo 10f. Zip Code 10g. Citizen of What Country? Bowers Avenue Funeral 21207 U S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc ģ 1 Never Married 2 x Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖈 No Specify. STWIH WORK Saltimore, Maryland 21215-003 Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Photo Tech na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Major Robertson Mary Privett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Smith-Son 3806 Bowers <u>Avenue Balto, MD 21207</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery6-25-2010 Balto Co, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 21202 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onse) and Death **▼llysicia**(i/ disease or condition resulting in death) ea Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the burian Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALIGATANT RT PIGGAL EFFUSION signed to 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 No Yes 2 No 1 Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1XX Natural injury Division 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print) BELVELERE AVE. BACTIMORE MD 21215 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Items 25,30 per dr., g904,06/24/2010dhb Certificate of Death Real No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth Month Dey 13 2010 Physician June 1:00 PM Aldona Mar Simanavishus /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Cheverly Prince Georges Prince Georges Hospital 9. Birthplace (State or Foreign Country) Lithuania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27, 5. Social Security Number 7. Age (In vrs. last birthdev) 6. Sex Days **Funeral** Months Hours 1 □ M 2 🔀 F 1922 88 577-58-7252 Director Usuel Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b County or 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Modical Exaction must be notified at 1 ☐ Yes 2 X No MD Prince Georges Lanham by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 9322 Wyatt Drive 20706 USA Pages 1 and 2 should be filed within 72 hours efter death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0020 1 ☐ Yes 2KINo Specify 3 Widowed 4 □ Divorced Year or Detes: Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 massage therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) ie merked of Pauline Stacaite Joseph Marshall 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health elimportant: if item 27 leany injury or other trau 9322 Wyatt Drive; Lanham, Maryland 20706 Laima Simanavichus - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5X Other (Specify) in State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Board; 655 West Baltimore Street Director Baltimore, Maryland 21201 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest cause on each line. Approximate Interval Between Onset and Death Part1. Enter the direase, or comshint, or heart failure. List only Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) by Physician/Medical Examiner PSI Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, ebsiella attending physic I for use as the b Due to (or es a consequence of) 23b. Did tobacco uee contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 6 1 ☐ Yes 2 ▼ No 2 ER/Outpatient After this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral ( 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth Medical Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medicat Examiner: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature end title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Linda D. Green, 3001 Hospital Drive, Cheverly, MD 20785 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JUN 2 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 1:45 PM Bernard Shaw June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7 Country Hill Court Fork 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under Social Security Number **Funeral** (Month, Day, ) June 4, Days Months Hours Min. 1 🛛 M 2 🗆 F Maryland 219-26-3713 74 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10c. City, Town or Location Director if item 27 is marked other than "natural", or items 23a or 28a-f so or other traumatic event, the Medical Examiner must be notified 1 🗌 Yes 2 💢 No Baltimore Fork MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21051 7 Country Hill Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 🙀 Yes 2 🗌 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Andy Nelson's Office Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Alexander Shaw Evelyn Irvin Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Country Hill Court- Fork, Maryland 21051 Carol Shaw-spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Gardens of Faith JUNE 25 2010 Rosedale, Maryland 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. Ust only one cause on each line.

Immediate Cause (Phal disease or condition) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Pmysician/ disease or condition resulting in death) Medical Examiner and Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to lu las MUDDINII the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last 2013 Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death 4 Pregnant
9 Unknown 23e. Did tobaccourse contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Dres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 1 🗌 Yes Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Man of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natura 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

forte

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17-19b, perSAB, G904, 6/24/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death

9: QB A M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 2010 Robert S. Thomas Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or HEALTH CARE MARYLAND SYSTEM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🗆 M 2 🗆 F Hours March Day Year) 1945 Washington, DC **Director** 234-76-2526 65 Usual Residence of Decedent or items 23a or 28a-f shov 10b. County unk permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Winchester VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 22601 31 Payton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married 2 □ No 1965-1 X Yes If Yes, Give Specify: white TO PHYSICIAN THOMAS Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 K Divorced 1973 Year or Dates 16a. Decedent's Usual Occupation UNK
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) -unk 2 Robert Stanton Thomas Sr. Lucille Margie Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Gladys Pape</u> – **step** 1845 Rosser Lane; Winchester, Virginia 22601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Signature of Funeral Service Licensee 12, 23 Marte Araroffish Board; 655 West Baltimore Street rector Baltimore, Maryland 21201 Enter the disease, or compile floor that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate use (Final Physician/ aryngeal Careinon a disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has been signed by the attending abundant man the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year 1 Yes 2 No iis certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Heart Disca 2 No 3 Probably 4 Unknown Chronic Obstructive Lung 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{\tint{\text{\tin}\text{\tinit}\text{\text{\text{\tinit}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\texi}}}\text{\text{\text{\text{\tinit}\text{\text{\text{\text{\text{\texi}\text{\text{\texitile}}\text{\text{\text{\text{\text{\text{\texi}\text{\texitile}\tint{\text{\texi}\text{\text{\texi}}\text{\text{\text{\texi}}\tint{\ti မ 1 Inpatient 2 ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director and the funeral director and the funeral director and the funeral direct Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) H0054439 June 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nincent A. Giminar Too VA MARYLAND HEALTH PARE SYSTEM PERRY POINT MA 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State IIIN 2.4 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** June 22, 2010 Eugene Paul Thomas 12:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Renaissance Gardens Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 003-16-0519 Director 82 Sept.15, 1927 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt CR216 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates 1946-47 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Design Engineer Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Varny Thomas Dorothy Morse 2 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna H. Thomas 715 Maiden Choice Lane, CR216; Catonsville, MD 21228 Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem.Garden 6/26/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): physician a Box 68760 Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed bo welles 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 20 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After ti 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date and place are considered at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely and manner stated. To the within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and my 0020080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO ~acu diken

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 4 2010

32. Registrar's Signature

Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 gay 7:30 PM **Physician** 2010 George B. Udvarhelyi June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Roland Park Place Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Months Days Hours 1X M 2□F 90 Yrs. Director 217-38-0586 May 14, 1920 Hungary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County and Mental Hygiene. is marked other than "natural" or items 23a or 28a-f show is marked other than "natural" or items 23a or 28a-f show resumante event, the Medical Examiner must be notified at 1∑Yes 2□No Director N/A Baltimore Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 830 West 40th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White Specify: þ Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Neurosurgeon Johns Hopkins permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, item 57 is marked other traumatic event, item 58 is marked other 58 is mar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Bakacs Bela Udvarhelyi ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2185 Wyndtree Lane Malvern, PA 19355 Ian Steven Udvarhelyi, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/23/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Iweek Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Inuck Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Years sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed 2□No 1☐ Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director /
completely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital 29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

77 Pan Belle Mac Gregor MD 29d. Date signed (Month, Day, Year) 29c. License number D13657 June 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. ISMBELLE THE TREEOR, 830 W 40 H Street, Backurer, Ra 21211 32. Redistrar's Signature State Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  AMEND TTEM#30perDVR, G904, 6/24/2010, WS State of Maryland / Department of Health and Mental Hygiene													
		•	1 - For State Registrar	State of Waryland	Certifica				g. No. 20	0 19807				
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Elizabeth		Walk	er		2. Date of Death Month	Day ZYe	3. Time of Death				
	Examin		4a. Facility Name (if not institution, give st Washington Adversed S. Social Security Number 6. Sex	ntist Hospit	tal To	Kon	Location of Death  1 A Pa  If Under 24 Hrs.	8. Date of Birth	1 2	Peath  Gomery  Birthplace (State or Foreign				
	Funeral Director			M 2 ≥ F 7. Age (my/s. la	Yrs. Months	Year), 1912	Country)							
	Maryland 8a-f shov tified at	Director	10a. State 10b. County	10c. City	Town or Location	ton				do of Business Industry  The Corp.  Jurname)  OSTEC  Town, State, Zip Code)  O.C. 20032  Station - City or Town, State  Mandale, Virginia  Approximate Interval Between Onset and Death  Onset and Death  Onset and Death  Approximate Interval Between Onset and Death  Onset and Death				
	s 23a or 2 nust be no	Funeral Di	10e. Street and Number 407 Xenia	St. S.E.	*Of Z	Zip Code	032	10	Og. Citizen of What	t Country?				
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amply injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes, sp	edent of His ecify Cuban 2 💢 No	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)						
21215-0036	within 72 hou giene. <b>ier than "nat</b> t, <b>the Medic</b> a	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)		life. DO NOT u	rork done du	iring most of work	ing	Mitre Corp.					
Maryland 2	d be filed w Jental Hyg arked othe Itic event,	To Be	17. Father's Name (First, Middle, Last) Frank	Johnson				ne (First, Middle, M		X				
, Mar	and 2 should be Health and Ment tem 27 is marked other traumatic e		19a. Informant's Name/Relationship (Type) Joyce Mozee -		19b. Mailing Addre	ss (Street a	nd Number or Run t. S.E.W	al R ute Number, o ashingtor	City or Town, State	, Zip Code) _0032_				
Baltimore,	permit. Page 1 ar Department of H Important: If iter any injury or oth once.		20a. Méthod of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗀 F 4 🗔 Donation 5 🗀 Other (Specify)	Removal from State	lace of Disposition (Nemetery, crematory or cat Valley Mean	r other place	)	Date 2	Α	1 1/				
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility  Chinn Funeral Service 2605 S. Shirlington Road Holington, Va. 22206											
	hysician/ Medical	8 9	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	sclerot	,	teart	Disc	ease	Interval Between				
-	Examiner	er	Sequentially list conditions.	Due to (or as a consequence).										
B.	executed ian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequ	111									
2092	icate be e g physicial is the buri	1edical		1										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate has been signed by the attending physici To the thereal Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d g ☐ Unknown	I death 3 🔲 Ectopi					· ·				
ds, P.O	v requires that the state of the state of the state of the should be detailed by the state of th	<u>چ</u>	Part II. Other significant conditions con	tributing to death but not resu	ulting in the underlying	g cause give	en in Part I.			te to the cause of death?  Probably 4 🕅 Unknown				
Division of Vital Records, P.O.	The law rec ate has bee page 2 sho	Completed						24a. Was an autops; perform	y prior n <u>ed</u> ? deat	e autopsy findings available r to completion of cause of th? Yes 2 □ No				
ital	ician: certific ector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		Othe	ce of Death (Chec r:	,						
of V	y Physer this eral dii	e: 70	27. Manner of Death		28b. Time of	28c. Injury	4 ☐ Nursing H at	ome 5 Reside 28d. Describe how	nce 6 Other (S w injury occurred	Specify)				
sion (	kttending death. ctor: Afte y the fun	Certificate:	1 🖰 Natural 5 🗌 Pending 2 🗍 Accident Investigation 3 🗍 Suicide 6 🗎 Could not be	(Month, Day, Year)  28e. Place of Injury - At hor	injury M me. farm. street, facto		yes 2□No	28f. Location (Str.	eet and Number o	r Rural Route Number,				
Dİ	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page?		4 Homicide determined  29a. Certifier 1 La Certifying Physic	building, etc. (Specify)	)		date and place, a	City or Town,	State)					
	the Ho nin 24 h the Fui npleted	Medical	only one) 3 Certifying Nurse	er: On the basis of examination Practioner: To the best of my	knowledge, death oc	curred at the	time, date and pla							
	wit To		29b. Signature and title of certifier	MID	2	9c. License	number	- 1	9d. Date signed (M	ZZ ZO/O				
	3		30. Name and address of person who co	mpleted cause of death (Item		Advent	tist Hos	pital Tal	koma Park	c, MD 20912				
	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 4 2010	32. Registrar's Signatu		-								

State Registrar

M000042122

MARUEY

, MD, 500 UPPLY

32. Regist ar's Signature

R. Fister

31. Date filed (Month, Day, Year)

Chesapeake Drive, Bel Air, Manyland Dich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bertha E. Walsch June 2010 :59A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Balto. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) Maryland 1 □ M 2 🗓 F Days Hours Director 220-20-9580 81 October .1928 Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MA Balto. White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10518 Vincent Farm Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Bruno Scholz Ida Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Kenneth Walsch, Jr. Son 6675 Lochhill Road Balto. Md. 21239 permit. Page 1 and 2 Department of Health Important; If item 2; any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XX Burial 2 Cremation 3 CRemoval from State cemetery, crematory or other place) Moreland Memorial 6-25-2010 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician. The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed 2 within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 \( \text{Yes} 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my pointion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 6/20/10 Name and address of person who completed cause of death (Item 23a) (Type, Print) Buson, MO 21204 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Items 29c, 30 pe	ryland / Depa <b>Cer</b>	904,0692 tificate of L	92 <b>0</b> 1 <b>63</b> Death	d Mental Hy	giene Reg. No. 2011	0 19810			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath _ Day Yea	3. Time of Death			
	Medic	al	MICHAEL WINCHES	STER			JUNE	16, 2010	4,40 PM			
	Examin	er	4a. Facility Name (if not institution, give street and number)  FREDERICK MEMORIAL HOSPI	ד∧ד.	4b. City, Town, or FREDE		eath	4c. County of De FREDER				
	Funeral		5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday)	If Under 1 Year	If Under 24 H		h 9. I	Birthplace (State or Foreign			
	Director			8 Yrs.	Months Days	Hours M	1in. July 5	1941 No	rth Carolina			
	nd <b>how</b> at	r	Usual Residence of Decedent  10a. State 10b. County - 1	10c. City, Town or Lo	cation				10d. Inside City Limits			
	faryla 8a-f s tified	Director	Maryland Baltimore		Baltimore	County	у		1 ☐ Yes 2XXNo			
	the N or 28		10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?			
	h with ns 23a nust l	Funeral	4505 Necker Avenue		212	236		USA				
	r deat or iten iiner r	y Fu	11. Marital Status  1 ☐ Never Married	er in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ar Black, WI	merican Indian, nite, etc.			
939	s afte ral", c Exam	ed by	3 Widowed 4 Divorced If Yes Cive Year or Dates.	° 1	☐ Yes 2 🔀 No	Specify:		Specify: W	hite			
5-0	hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occup		working	16b. Kind of Busines	ss Industry Uthority of			
121	thin 73	Completed	12 yrs. N/A		NOT use retired)	aring most or r	roning	Baltimore				
d 2	led wi Hygid other ent, ti	രാ	17. Father's Name (First, Middle, Last)	•		18. Mother's	Name (First, Middle,	lle, Maiden Surname)				
ylan	ld be fi Mental arked atic ev	မ	Worth Hugh Winchester				nia Verl M					
, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Pauline C. Winchester (Wife					r, City or Town, State, Md. 21236	Zip Code)			
Baltimore,	le 1 an t of He If iten or oth		20a. Method of Disposition  XIX Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, crem	natory or other plac	e)	Date	20c. Location - City	·			
<u>=</u>	iit. Pag artmen ortant: injury		4 Donation 5 Other (Specify)	Dulaney V			21-2010	Baltimore				
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licensee	re, Maryla	nd 21236							
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition)											
	h sician/ Medical	Immediate Cause (Final disease or condition resulting in death)  Onset and Due to (r as ) consequence of):  Onset and Onset an										
	Examiner	_		echwo	nia							
	p it d	Examiner	cause. Enter Underlying			1	failu					
	ecuter and I-trans	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a c.	d Sta	je re	n al	Tonlu	<u> </u>				
09	certificate be executed nding physician and use as the burial-transit	edical	d	, ,								
6876	ificate ng phy as the	Med	IF FEMALE:									
9 X	th cert ttendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	☐ Fetal death 3 ☐		у		23d. Date of o				
	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1  Yes 2 No 4 Pregnant at ti	ime of death 5 ∟	Other (specify)			WORLT	Day Year			
P.0	requires that the been signed by t should be detach	by Pt	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
ds,	quires en sigi nuld be	ted t					_ 1 🗆 `	/es 2 No 3 □	Probably 4 🗆 Unknown			
co	law rei has be e 2 sho	Completed					24a. Was a	sy prior t	autopsy findings available o completion of cause of			
e R	: The						perfor	med? death	? ∕es 2 □ No			
<u>.</u>	sician certifi irector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatien			ace of Death (C	- 1014 Ph. 10					
<u>,                                    </u>	g Physer this eral d	e: To	27. Manner of Death 28a, Date of injury	t 2 ER/Outpatien 28b. Time of	28c. Injury	at		ence 6 Other (Sp. ow injury occurred	ecify)			
0	endin eath. or: Aft he fur	fical	Natural 5 Pending (Month, Day, 1)  Accident Investigation  Suicide 6 Could not be	/ear) injury	M 1 □	/ Yes 2 ☐ No						
Division of Vital Records,	or the hospital or Aftending Physician: The law within 24 hours after death.  To the Funeral Directors After this certificate has completed filled in by the funeral director, page 2 and page 2.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (	- At home, farm, stre S <i>p</i> ec <i>ify)</i>	et, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,			
	pspital hours ineral d filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my	y knowledge, death o	ccured at the time,	date and place	e, and due to the cau	use(s) and manner as	stated.			
:	the Ho nin 24 the Fu nplete	Med	(Check 2 ☐ <b>Medical Examiner:</b> On the basis of examiners only one) 3 ☐ <b>Certifying Nurse Practioner:</b> To the be	mination and/or invest st of my knowledge, d	igation, in my opinic leath occurred at the	n, death occurre time, date and	ed at the time, date and place, and due to the	nd place, and due to the cause(s) and manner	e cause(s) and manner stated. as stated.			
	5 ± 5 6 6		29b. Signature and title of certifier	A / c	29c. License <b>D35106</b>			29d. Date signed (Mor				
			30. Name and address of person who completed cause of dear	th (Item 22a) /Time D				6/16/	2010			
\			Myung Hee Nam, 400 W. 7th	St., Fred	erick,MD							
Ì	Stat Registra	-	31. Date filed (Month, Day, Year) JUN 2 4 2010	Signifture for	es!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 20 Leta Mae Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** al Cumorp If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖳 F **Director** 458**–**16**–**3428 June 21,1912 Texas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evantual must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2x No Funeral Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 715 Maiden Choice Lane CR404 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 🙀 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. ò White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Social Security Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 John Albert Middleton Edna Lillian Cain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry W. Wilson <u> 2530 Kensington Gardens Unitl04;Ellicott City,MD 21043</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Sta 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State S Other (Specify) Atlantic Crematory 6/23/2010 4 ☐ Donation Glen Burnie, MD 21. Signature of Fure ral Service Liounge 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending pl for use as ti IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) been signed by the 9 Unknown Part II. Other significant conditions contributing to death, ut not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

12

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

rally

30. Name and addr-ss of person who completed cause of death (Item 23a) (Type, Print)

Macken

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 21 Physician/ LEIGH ANN WOOD 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Glen Burnie Health and Rehabilitation Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min. Feb 5. 1920 West Virginia 234-26-8016 90 **Director** Usual Residence of Decedent show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Anne Arundel 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21225 110 Tenth Avenue USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Board of Education 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel County Be 18. Mother's Name (First, Middle, Maiden Surname)
Ellen Ligget 17. Father's Name (First, Middle, Last) ည Charles Hutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Wood, II (Son) 110 Tenth Avenue, Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Brick Church Cemetery 6/25/10 Huttonsville, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Fineral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 4 cas Medical Due to or as a consequence of Examiner DEMENT'A MEI Sequentially list conditions, Due to for each donsequence of cause. Enter Underlying Cause (Disease or iinjury Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown nis certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has be also a second of the second of t autopsv perform ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ithin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFHLLPA 3001 S. HAWOVERST, BALAMONE MD 21225 31. Date filed (Month, Day, Year) JUN 2 4 2010 32. Registrar's Stgnatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2010 Emory Fulton Watts, 9:30 P.M Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 116 Governors Court Apt. B Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Hours 02728/1926 219 18 7650 Mary land Director 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Governors Court Apt. B 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: "natural", 3 Widowed 4 Divorced Year or Dates. WW II Completed White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Electrician Watts Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emory Fulton Watts Sr. Myrtle Haun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Watts / wife 116 Governors Court Apt. B Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4 ☐ DOINGTON.

21. Signature of Finneral Service (1) 06/24/2010 Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ RENAL ENDSTAGE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death signed by the a a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by PAILURE HEART 1 Yes 2 No 3 Probably 4 Unknown Completed OBSTRUCTIVE PULMONARY CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed certificate 1 Yes 2 No 2 N 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after decal Director; After how the fi 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investi**g**ation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 20017753 6-21-2010 Aunglus, mish

Pax,

Registrar
DHMH 17 Rev 7/2009

POTEE ST

BALTIMORE, MD 2 1225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7, M.D. 3

KISI DHARMASENA

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{\tiny Day}}{2}\,0\,1\,0$ June LAWRENCE 15 10:28 aM **JERRELL** WOODS, JR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Ctr Baltimore Towson 8. Date of Birth (Month, Day, Year) 201 0 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 1**X** M 2□ F Months Hours MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD HARFORD BELCAMP 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1303 LIRIOPE COURT, APT. 201 21017 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A NZA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LAWRENCE **JERRELL** WOODS, SR. CARLETHIA DeSHON SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21017 19a. Informant's Name/Relationship (Type. Print) 1303 LIRIOPE COURT, APT. CARLETHIA SMITH/ MOTHER 201, BELCAMP, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 6/23/10 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ne and Address of Facility LY & ZEILER INC. FUNERAL HOME 1 EASTERN AVENUE, BALTIMORE, MD 7907 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Severe respiratory distress syndrome hours Due to (or as a consequence of): Prematurity 1/7 week restation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 11 hours Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 T Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypotension 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760. signed by the a page 2 should ieral Director: After this certification of the funeral director,

Examiner Physician/Medical 2 Be Completed Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

ð

Completed

Be

1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. Items 23 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, if a Madical Examinan must be notified at

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic events.

**Physician** 

Examiner

/Medical

Bilateral pneu Suspected seps			24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☒ No			
25. Was case referred to medical examiner?		26. Place of Death (	th (Check only one)				
1 Yes 2 No	Hospital: 1 ∰Inpatient 2 ☐ ER/Outpatient 3 ☐ Do	OA Other: 4 Nursing Home	lome 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury	y occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	, office 28	f. Location (Street and City or Town, State)	d Number or Rural Route Number, )			
29a. Certifier 1 Certifying Ph	niner: On the basis of examination and/or investigation	at the time, date and place, ar , in my opinion, death occurred	nd due to the cause(s) I at the time, date and	and manner as stated. I place, and due to the cause(s)			

29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

29d. Date signed (Month, Day, Year)

ocha

31. Date filed (Month, Day, Year)

701

Register's Signature

STREET, Baltimore

State Registrar

within 24 hours after death.

To the Funeral Director: /

ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year June 19 Medical <u>Shirley Lavinia Zacharko</u> 2010 :50P 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Brinton Woods Nursing Home Sykesville Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🗆 M 2 ី F Months Hours Min. Director 219-16-4065 8.5 1925 Maryland Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. 1 Yes 2 X No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1511 Brehm Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည James G. Kling Elsie V. Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Joseph P. Zacharko Son Brehm Rd. westminster. Md. 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview 6-21-2010 Balto. Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Mebspare Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Director: After this certificate 2 1 No Yes filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) Tullan 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATRICK

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2010 /Medical 4a. Facility Name\_(If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LOCH KAVEN COMMUNT 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. tv⊠M 2□F Director 215-12-0219 87 Jan. 30, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show 1 Yes 2 No Director N/A Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with inent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 3439 Pleasant Place 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: 3 Widowed 4 □ Divorced White WWII event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be If item 27 is marked or other traumatic ev 2 Zukowski John Stanislawa Gurna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Sutch Daughter 3607 Ash Street Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or Crownsville VA Cem. 6/23/2010 Crownsville, MD 21. Signatule of Puneral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21211 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any knowing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ANo Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 114 LOCH RAVEN

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Edward A. Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country)
Pennsylvania Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours 06-07-1955 1 XM 2 - F 55 199-44-7284 Director Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2♣ANo Franklin Guilford Twp. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 17222 USA 3285 New Baltimore Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2¾2¾No Black, White, etc. ō ģ 1 Never Married 2 X Married Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes Give "natural". Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Technician Mack Truck Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) မ Mary Jane Moyer Edward A. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3285 New Baltimore Road, Fayetteville, PA. 17222 Karen M. Brown Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Strang's Cemetery 1 X Burial 2 Cremation 3 Removal from State 17161 6-18-2010 South Mountain, PA. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic se 22. Name and Address of Facility Thomas L. Geisel Funeral Home M01346 17202 Falling Spring Road, Chambersburg, PA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Harosclorot disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** > 5 pertanis Sequentially list conditions, Examine to (or as a consequence of) if a. y leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2  $\square$  No ER/Outpatient 3 DOA မ 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Chec 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29d. Date signed (Month, Day, Year) 29b. Sia MO Dog s of person who completed cause of death (Item 23a) (Type, Print) 30. Nam and a Kotel DM 6 31. Date filed (Month, Day, Year) JUN 2 4 201 Registrar

State of Maryland / Department of Health and Mental Hygiene

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			For State Registrar	State of M	-	•	ficate of D		Mentai riy	Reg. No				
			Decedent's Name (First, Middle, La	ast)		00/1/	Troute or E		2. Date of D		o	3. Time of Death		
Н	Physicia Medic		Robert Lee Brus	sh					June	10, <sup>Da</sup>	<sup>a</sup> 2010 <sup>Year</sup>	9:50 А м		
	Examin		4a. Facility Name (if not institution, giv	e street and number)				Location of Deat	h		. County of Death			
	/		Harmony Hall				Columbia				ward			
	Funeral Director		061-14-8878	Sex 1 <b>X</b> M 2 □ F	e (In yrs. last birtl		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di Jan 6,	av. Year)	Coun	try)		
	nd how at	<u> </u>	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locat	ion				T-	0d. Inside City Limits		
	arylar la-f s ified	Director	MD Howard		Columb							1 ☐ Yes 2X No		
	or 28		10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cour	th thiplace (State or Foreign buntry) SSOUri  10d. Inside City Limits 1  Yes 2X No ountry?  erican Indian, te, etc. iite Industry  Research  ip Code)  r Town, State MD  DX 784 e, MD 21029  Approximate Interval Between Onset and Death  APATO		
	s 23a s ust b	Funeral	6336 Cedar Lane #	¥171			21044			USA				
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 2 Yes 2 1 If Yes, Give Year or Dates.	No		s Decedent of His es, specify Cubar Yes 2X No	spanic Origin? (S) n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Americ Black, White, Specify: Whi	etc.		
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212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5	)+)		tion Mar	ager		Ecc	nomic Re	search		
	tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)					18. Mother's Na			Surname)			
Maryland	should be file h and Mental h 7 is marked o raumatic eve	-	Peter F. Brush					Elizabet						
	and 2 sho Health and em 27 is r		19a. Informant's Name/Relationship ( Peter N. Brush/so		195.	Mailing /	Address (Street a Bushy Ta	nd Number or Ru il Run V	ral Route Numb Noodbine	er, City or	ty or Town, State, Zip Code) MD 21797			
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition    Date   Double   Computer											
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	Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition		Approximate Interval Between Onset and Death									
ne"	Medical Examiner		resulting in death)	Due to for as a	a consequence o	1):	Lyd	DISEANCE Humenus	Larren	uč		4165		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. ———	a consequence o	nt):		CERTIFICATION NO.	- ANCI	T EXYMINI	ER.			
	scuted and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as	a consequence o	n.		TOP HOTTON	BONED BY MEDIC					
0	ificate be executed g physician and as the burial-transit	Medical E	resulting in death) Last	d	a consequence o			CERTIFICATION	100					
68760	ificate ig phy as the	Med	IF FEMALE;											
Box	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2  Fetal death		ctopic pregnanc Other (specify)	y -			23d. Date of delive Month	,		
P.O.	ires that the signed by d be detact	by	Part II. Other significant conditions	_	ut not resulting ir	n the und	erlying cause give	en in Part I.				_		
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Ž	Physi this cral dir	<u>1</u>	1 √Yes 2 No  27. Manner of Death	1 Inpatie	ent 2 ER/Out		3 DOA Othe	4 L Nursing F			Other (Specify	, Asset Living		
0 0	Attending Physician: er death. ector: After this certific by the funeral director,	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Da)	, Year) in	Jury 300	4 monte		28d. Describe		Standing	Position		
isio	I or Attendatendeat Director:	rtifi	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Inju	ıry - At home, far	<u> </u>					d Number or Rural			
Σį	talor rsafte al Dir ed in	Ö		Subjects	ADAY + ME	ut in	v Bedroo	m	6336 CEC	NN, State	ANE Colu	mbia. MD		
	To the Hospital or within 24 hours after to the Funeral Direction completed filled in I	Medical		ysician: To the best of								d. use(s) and manner stated		
	To the h within 2 To the F complet	Me	only one) 3 Certifying Nu	rse Practioner: To the			th occurred at the	time, date and pla		ne cause(s	s) and manner as st	ated.		
	<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier				29c. License	21/V/AV			te signed (Month, I	uay, rear)		
			30. Name and address of person who	completed cause of de	eath (Item 23a) (T	vpe. Prin	t)	77868						
	5+1		Here Diener	1055 LI	re Patry		pe C	columbus,	mo		71844			
	Stat Registra		31. Date filed (Month, Day, Year)	32 Aegistra	r's Signature	ha.	W. J	/						

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1225 PM Dorzhack Berridge 201O June /Medical County of Deat 4b. City, T wn, or Location of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year)
AUG. 1, 1928 9. Birthplace (State or Foreign If Under 1 Year 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Min 1 □ M 2 X F GERMANY 222-16-5804 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a, State 10b, County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at SUSSEX DELAWARE SEAFORD 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19973 27288 WOODLAND ROAD AMERICA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Specify.WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3X Widowed 4 ☐ Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES STORE MANAGER 12 18. Mother's Name (First, Middle, Maiden Surname)
ELSIE MARTHA FROHBERG 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be LUDWIG DORZBACH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 NYLON BLVD. SEAFORD, DELAWARE 19973 19a. Informant's Name/Relationship (Type. Print) ELSIE D. ROHLICH NIECE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If its any injury or o CREMATORY Of her place) 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) 6/9/10 DELMAR, DELAWARE 4 □ Donation DELMARVA 21. Signature Fund al Service Li WATSONG TES FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DE. 19973 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Part1. Ent he di shock, o'll eart fail or complications List only one cause Immediate Caus (Findisease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1⊟ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No Certification: To ¥≛Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Vithin 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 ×450 1 Certifying Physician: To the best my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) è

State Registrar 31. Date filed (Month, Day,

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ge 710 Obrecht Rd, Sykesvi

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AMEND ITEM#14perFH, G905, 7/6/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month )0/10THEA Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Retirement Baltimore Parkville 8. Date of Birth (Month, Day, Year) Sept 9, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 D F Country) Maryland **Director** Yrs 213-14-8018 89 Usual Residence of Decedent 28a-f shov 10a, State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Baltimore Parkville 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8820 Walther Boulevard 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or δ Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify. Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) unk College (1-4 or 5+) unk bookkeeper Bendix Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Robert Duerling Mildred Viola McGill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Duerling - niece 1800 Valleybrook Drive; Kingsville, Maryland 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) uneral sprice Licensee Cona d S. Wade, Signature <sup>22</sup> State Anatomy Board; 655 West Baltimore Street 21 Baltimore, Maryland 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician hemorrhan Stoke disease or contion Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? detached for Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed' certificate 1 Yes 2 No funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 AH မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural (Month, Day, Year) 5 Pending work? Division 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Frentioner: To the Sest of my knowledge, death began at the firm date and plane, and due to the naissets) and manner as stated 29b. Signature and title of certifi License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) weth Seco 32. Registr State Registrar

mo.

6:15

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year STher 6:55 A M lians Medical LANC 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 273 Potomac Heights Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Aug 17 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F ,1949 Maryland 214-54-2467 60 Yrs Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral U.S.A. 21742 273 Potomac Heights 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Cashier Retail Store 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Violia Snyder Baker Warren Donald Baker, Sr. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13944 White Oak Ridge Hancock, MD 21750 Department of Health ar Important: If item 27 is any injury or other trauonce. Torrie Baker-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Haven Cemetery 6-14-20 0 Hagerstown, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald E. Thompson F. P.O. Box 310 Clear Spring, MD 21722 21. Signature of Funeral Service Licenses P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a construence f): disease or condition resulting in death) 0 Medical Examiner VO NOTY arter. Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) hinty seva law requires that the death certificate be executed Stenssi and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Iwelve physician Physician/Medical 4 care Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ğ Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an y has prior to completion of death? autopsy performe page 2 Hospital or Attending Physician: The this certificate 2 No Yes 2 1 Yes after death.

Director: After this certification of the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one 29b. Signature and 29c. License number

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Hiserstown

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	or 2%		10e. Street and Number		-		10f. Zip Code			10a. 0	Citizen of What C		
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36.	", or	ρ	1 Never Married 2 Marrie	d 1 Yes 2 1	lo		Yes, specify Cuba		o rican, etc.)		Black, Whit	e, etc.	
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آ an	be f lenta rked ic ev	은	Edward Cason	Bennett					ne Gral		•		
ary ary	and M	l s	19a. Informant's Name/Relationship	(Type, Print)	19b.	. Mailind	Address (Street a	and Number or Ru	ral Route Numbe	er. City i	or Town, State, Zi	n Code)	
Ze	d 2 sl atth a 1 27 is		Laura J. Benn	ett / wife	- 1		9 River						1
Bennett <b>nore, Mary</b>	1 an of He item		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of atory or other plac		Date	_	Location - City or		
Benn <b>Baltimore</b> ,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				lopen (		9/2010	$ _{\mathrm{Fr}}$	anford	DE	
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	Attending Physician: The law requires that the death certificate be executed at death.  The death.  Ector: After this certificate has been signed by the attending physician and extors thereful director, page 2 should be detached for use as the burial-transit.	Physician/Medical Examiner				-,-							
Box 68760	cate   phys	edic		d								_	
89	certifi nding se as	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of de	liven	
ŏ	eath o	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live Birth 2 4 ☐ Pregnant at t			Ectopic pregnanc Other (specify)	у		- 1	Month	Day	Year
Э.	hat the de ed by the detached	hys	g Unknown	9 Unknown									
P.O.	that ned b	by P	Part II. Other significant conditions	contributing to death but	not resulting in	the un	derlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of	death?
of Vital Records,	v requires that s been signed I should be det	ed	-40						1 🗆	Yes 2	2 🗆 No 3 🗆 P	robably 4 2	Unknown
Ö	aw rec as bee 2 sho	Completed							24a, Was		24b. Were au prior to	topsy finding	s available
že	The la	mo.							auto perfo 1 🗆 Yes	ormed?	death?	2 No	cause or
<u>a</u>	ician: The certificate ector, pag		25. Was case referred to medical examiner?	1			26. Pla	ace of Death (Che		-	10 10	2 110	
Ξ	hysic iis ce I direc	2	1 ☐ Yes 2 No	Hospital: 1  Inpatien	t 2 🗆 ER/Out	tpatient	3 DOA Othe	r: 4 Nursing H	ome 5 - Resid	dence	6 ☐ Other (Spec	ify)	
of	ng P		27. Manner of Death  1 X Natural 5 Pending	28a. Date of injury (Month, Day,	Year) 28b. Ti	ime of ijury	28c. Injury work	at	28d. Describe I				
ioi	tendi leath. tor: A the fu	ijį	2 Accident Investigat 3 Suicide 6 Could not	he -			M 1 □	Yes 2 No					
Division	or At after c Direct in by	Certificate:	4 Homicide determine			m, stree	t, factory, office		28f. Location (S City or Tox		nd Number or Rui e)	al Route Nur	nber,
	pital ours a eral [		29a, Certifier 1 Certifying Pt	T. II. 1 - 1 - 1 - 1		I		data and data					
:	e Hos 24 h Fun e Fun leted	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exa urse Practioner: To the be	mination and/or	investig	ation, in my opinior	n, death occurred a	at the time, date a	and plac	e, and due to the	ause(s) and n	nanner stated.
	To the hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completed filled in by the funeral director,	— 1	29b. Signature and title of certifier	)	St Of Thy Knowle	Jage, de	29c. License		oc, and due to th		ate signed (Month		
			> Gennie 2	avage C	RNP		R13	5131		(	19/11	>	
		ŀ	30. Name and address of person who	- 0	th (Item 23a) (T	ype, Pri		1					
D	H20		Pennie Savage	, CRNP 97	15 He	alt	hway Dr	, Berl	in, MD	2	1811		
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar's									
	Registra	r		2010	. 1	100	ales						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 18, 2010 Vernon Holmes Chenoweth 10:27A M Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Center for
Hospice Care **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign If Under 24 Hrs **Funeral** 8. Date of Birth 1 XM 2 □ F Months Davs Hours Min July 2, 215-32-6781 Director 75 1934 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2X No MD Parkton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20713 Old York Road 21120 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceded Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <sup>№</sup>1954 1956 1 Yes 2 No Specify. If Yes Give Completed 3 Divorced 4 Divorced Specify: White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Howard Chenoweth Mildred G. Kempske 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Chenoweth/Wife 20713 Old York Rd., Parkton, MD 21120 Department of Healti Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State June 2010 White Hall, MD West Liberty Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee J.J. Hartenstein Mortuary 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ongestive disease or condition resulting in death) Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a conse wence of To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rs after death. al Director: After this certificate ha led in by the funeral director, page performed? Yes 2 WNo 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Manger of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3XX Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number R125913 ature and title of certific who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person N. CHARLES ST BALTIMORE, MD 21204

State Registrar Date filed (Month, Day, Year)

WN 2 4 2010

DHMH 17 Rev 7/2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUN 5 2010 Year Physician/ MATTHEW SAMUEL CHIGWIDA 8:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, MAY 10, Days 26 Hours 1 x M 2 | F MARYLAND Director 696-14-9620 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1.∏ Yes 2 ☐ No VIRGINIA ALEXANDRIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 EAST RAYMOND AVENUE 22301 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 24 No Black, White, etc. 0 1 X Never Married 2 Married ò ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: FILIPINO Hygiene. If Yes, Give 3 Wildowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NONE NONE marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ SIMBA CHIGWIDA MARY LYNN D. DEMONTEVERDE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 SIMBA CHIGWIDA - FATHER permit. Page 1 and 5
Department of Healtl
Important: If item 2
any injury or other t EAST RAYMOND AVENUE, ALEXANDRIA, VA 22301 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ROSE HILLS MEMORIAL PARK 06/17/2010 4 Donation 5 Other (Specify) WHITTIER. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON STREET, ALEXANDRIA, VA 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ NECROTIZING ENTEROCOLITIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Exam requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician a burial-Physician/Medical phys the L attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2  $\stackrel{\square}{\longrightarrow}$  No 3  $\square$  Probably 4  $\square$  Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) B examiner? Other: 1 Yes 2 🔀 No ္က 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 \( \subseteq \text{Yes} \) after death.

Director: Aff 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical 29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете Medical Examiner: On the besit of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practione/: To the besit of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature 29c. License number D65419 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER 12 MC USA BETHESDA MD 20889-5600 AGNES SIEROCKA LTC 31. Date filed (Month, Day, Year JUN 1 1 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 3, 2010 Steven Gregory 5:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stellamaris Catholic Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec. 15, 1956 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Maryland Director 577-78-8268 53 Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Timonium 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 21093 2300 Dulaney Valley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government State Department Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Colleen E. Anderson Charles E. Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 Leister Drive Silver Spring, Md. Charles E. Cooke/ Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date June 11, 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 2010 21. Si nature of Funeral Service Le 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RETHRAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

"Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29c. License number eted cause of death (Item 23a) (Type, Print) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Ingeborg Fink Covell 9:00 AM uns 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Washington 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Date of Bird. (Month, Day, 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Czechoslovakia Days Hours Min 215-74-0029 **Director** Ĩ934 lugust Usual Residence of Decedent 28a-f shov 10b. County 10a State 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a United States 21742 11540 Selema Drive, Apt. 12 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏝 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify.White "natural" Completed 3 Midowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Retail Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental toportant: If item 27 is marked of any injury or other traumatic everages. Karl Fink Anna Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8506 Tallwood Rd., Lutherville, MD 21093 19a. Informant's Name/Relationship (Type, Print) Harvey Morrell Son 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) June 1 Burial 2 Cremation 3 Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. MD 21701 catoctin Mountain Hwy. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of the cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequent of disease or condition 10151 Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a nonsequence off Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. -tran and that initiated events Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1typertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has I in by the funeral director, page 2 s autopsy 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do0 54451 June 8 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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~	Medi	cal	Clarence Edwa: 4a. Facility Name (if not institution, give street and nun		Cramer,		June	11 Day	20 <sup>Year</sup> 0	1905	$\mathbf{P}^M$
****	Examir	ıer	Washington County Hosp:	,	Hagers	or Location of Dea town	th		nty of Death A <b>shingt</b>	:on	
	Funeral	Г	5. Social Security Number 6. Sex 1 1 ★ M 2 □ F	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr		1	9. Birtho	lace (State or	Foreign
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	land show d at	ģ	10a. State 10b. County	10c. City, Town or Lo	cation				1	0d. Inside City	Limits
	Mary 28a-f	Director	MD Washington	William.	<del></del>					1 <b>X</b> ] Yes 2	2 🗆 No
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lanc	be file ental F ked o ic eve	일	17. Father's Name (First, Middle, Last)  Clarence G. Cramer				me <i>(First, Middl</i> e, <i>N</i>				
ary	hould and M is mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		ural Route Number,			ode)	
Σ,	nd 2 s lealth m 27 i		Nora L. Cramer/Wife				William:			1795	- 1
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from		natory or other pla	· · ·	- 1	20c. Locatio	n - City or To	wn, State	
Ħ.	nit. Pa artme ortani injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Rest Have	n Cemete  . Name and Addre				stown,		
ñ	permii Depar Impor any in	1	> S. Mark Supp			sylvania	Rest Have Ave., Ha	n rune gerste	erai Cr own. M	nape⊥ ) 2174	.2
۴	h sician/		23a. Part 1. Enter the disease, or complications that c shock, or heart fallure. List only one cause Immediate Cause (Final disease or condition							Approximate Interval Betwe Onset and Dea	een
	Medical Examiner		resulting in death) aa.	or as consequence of):	retor	CIL	. ^ 2				
		Jer	Sequentially list conditions, b. ———————————————————————————————————	or as a consequence of):	1200	Talu					
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	whe myee	avola	1 Falls 1 Infa	rchois				İ
	ate be executed ohysician and the burial-transit	al Ex	resulting in death) Last Due to (	or as a consequence of): UNG CAM	_	0					
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89	eath certificat attending ph	M/M	Zob. Was accedent pregnant	come of pregnancy Birth 2  Fetal death 3	15			23d. [	Date of deliver	v	
O. Box	the death by the attu tached for	Physician/Me	1	ant at time of death 5 own	Other (specify)					Day Yea	ır
ds, P.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the une	nderlying cause give	ven in Part I.	23e. Did tob			cause of deat	
Vital Records,	Ine law re ate has be page 2 sho	Completed			-2		24a. Was an autops perform	y ned?		sy findings ava	
ta .	cran: Sertific ector,	Be	25. Was case referred to medical examiner?	1		ace of Death (Che		110	1 1 103 2	TE NO	
> i	r this eral dir	<u>م</u>	27. Manne Death 28a. Date of	npatient 2 ER/Outpatient of injury 28b. Time of	Othe	4 ☐ Nursing F	ome 5 Resider				
on :	ath. rr. Afte	icat	2 Accident Investigation	n, Day, Year) injury	work		Zod. Describe Nov	v Injury occu	rred		
Division of	tal or Atter rs after de al Directo ed in by th	al Certificate:		of Injury - At home, farm, streeg, etc. (Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Num State)	ber or Rural F	Route Number,	
3	no use nospital or Artending Priysician: The law requires that the deswithin 24 hours after death.  To the Funeral Directors After this certificate has been signed by the acompleted filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Physician: To the besiconly one Certifying Nurse Practioner: To	s of examination and/or investi	gation in my opinic	on death occurred	at the time date and	place and a	lue to the cour	o(a) and manna	er stated.
	20 with		29b. Signature and title of certifier	1 000	29c. License				ed (Month, Da		
		-	30. Name and address of person who completed cause	COL. I	100	7113	1	Jun	17	1201	U
31	4-0+1		JERRY L. COPPEC	man D.	11240	PAL C	T., HAG	HEP-STO	DWN,	MD ZI	1740
	State Registra	-	31. Date filed (Month, Day, Year) 32. Rg	jistrar's Signature	-41		•				
21.11.4	H 17 Pay 7/200		JUN & 3 KUIU	asser p. A	O Section 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #19a,6/10/10, per FH, D.H. Certificate of Death WCHD Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Theodore Cooper Medical 10 2010 6:03 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11415 St. Martin Neck Road Bishopville Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yea Birthplace (State or Foreign Country)
 MD Funeral 8. Date of Birth (Month, Day, Year) 1**x** M 2 □ F Months Days Hours 66 Director 215-38-1769 9/28/1943 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11415 St. Martin Neck Road 21813 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give o. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction <u>Maintenance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Garman Cooper <u>Sadie Hadder Simpson</u> sa Informant's Name/Relationship (*Type, Print*) **Diana Cooper** Dianna Cooper / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11415 St. Martin Neck Road, Bishopville MD 21813 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important; If ite any injury or ot 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 6 ☐ Other (Specify) <u>Henalopean Crem</u> 6/11/2010 Frankford DE 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 108 William ST mile The Burbage Funeral Home Berlin MD 21811 23a. Pat 1 Inter the diseas om a cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failur ist only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Physician/ disease or condition resulting in death) Left kg Medical Examiner Peninhenal Vascular Disease 48985 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exam death certificate be executed Dioberes Mellitus ng physician and as the burial-tran 18CALS that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Cordiomyopathy Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown End Stage Renal Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed Yes 2 death? 2 🗆 No 25. Was case referred to medical examiner?

1 Yes 2 No of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🚰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifie 29d. Date signed (Month, Day, Year) D30619 Vune 10 2010 els 87001V

State Registrar

DHMH 17 Rev 7/2009

10445 Ocean Coby BIVd

32. Registrar's Signature

Suite 1

Berlin Md Z1811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AM TTO ENCY

ntuc u t Will

31. Date filed (Month, Day, Year) -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June OS 20**°**0 08:40 Ам Paul Albert Duchene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Chesapeake Hospice House Harwood 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours 05/24/24924 Confrecticut 86 Director 578-22-6328 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Anne Arundel Edgewater 1 🗌 Yes 2 🗖 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21037 129 Claiborne Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) N.S.A. Logistics Management Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola May Adams August Alphonse Duchene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Claiborne Road, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type, Print) Robert A. Duchene/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State MD National Memorial Park 06/14/2010 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funer 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Eryer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PLASTIC SYNDNONIE Y1200745 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PUS TATE Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 🗌 No 2 🗆 N Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ this Within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral results. 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d, Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical TO Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nuise Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier ٩ 108118 BIBSIGNTE RD BANDONS DO ZIYUT 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C100 32. P gistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 8:11 OM June Donald Eugene DUNN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney Keedy Nursing Home Washington Boonsboro If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 90 Director Oct. 1919 Virginia 225-09-8215 11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10827 Coffman Avenue 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ð Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Customer Service Rep. Utility Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Dunn Emily (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Louise D. Wine - Daughter</u> 1908 Maplewood Drive, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hebron Cemetery: 6/16/10 Winchester, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Zal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mellen /Medical Examiner adrey de eeus Sequentially list conditions, if my leading to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse ju Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a Ö 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown has been signed to a should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate 2 💆 No 1 ☐ Yes 1 ☐ Yes : After this certific funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 🕱 Vo Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident Injury 5 Pending nours after death.

Peral Director: Af investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 hours after die Funeral Direct 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 728363 6-14-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3H-21

State Registrar

DHMH 17 Rev 1/2001

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		ertificate of Death	Re	eg. No.2010 19832
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Donald F. Do	o <b>i</b> ittlE		2. Date of Death	Day Year 2010 2:10 P M
1	/Medic		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Dea		4c. County of Death
and the	Examin	er	13044 Old Bridge B		Ocean City		Worcester
	Funeral Director		5. Social Security Number 6. Sex 102-16-0581	7. Age (In yrs. last birthday	Months Days Hours Min		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Maryi	to	MD Worcester	ocean ocean	City		1 □ Yes 2 No
	r 28a	Director	MD Worcester  10e. Street and Number	.   Ocean	10f. Zip Code	1	0g. Citizen of What Country?
	th with	al D	13044 Old Bridge B	Road	21842		USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Indical Francinal in Indition any once.	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s Decedent Ever in U.S. ped Forces? Yes 2 \( \) No ss, Give ar or Dates:	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puel 1 □Yes 2X No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	nin 72 ho e. in "natur wedical	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dec (Giv life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business/Industry
21	d with	Con	12		ervisor		Electrical
nd	be file	Be	17. Father's Name (First, Middle, Last)	i+-10		me (First, Middle, M	Maiden Surname) ne Bisnett
ryla	2 should be and Mental is marked craumatic ev	မ	Floyd Gilford Dool  19a. Informant's Name/Relationship (Type. Print)		ling Address (Street and Number or F		
, Ma	and 2 shealth an n 27 is r		Betty Lee Doolitt	e/Wife 130	44 Old Bridge	Rd.,Ocea	an City, MD 21842
Baltimore, Maryland	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place) nlopen Crem. 6		20c. Location - City or Town, State  Frankford, DE
Balt	permit. Departr Importa any Inju		21. Signable of Funeral Service Licensee		22. Name and Address of Facility $_{ m B}$	-	Funeral Home n. MD 21811
	Physician /Medical Examiner		resulting in death)	that caused the death. Do not er	nter the mode of dying, such as cardia		est, Approximate Interval Between Onset and Death
		iner	cause. Enter Underlying	ue to (or as a consequence of):			
68760,	ifficate be executed g physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):			
687	tificate og phys as the	edical	d				
O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
Division of Vital Records, P.O.	ilcian: The law re certificate has bee ector, page 2 sho	Completed	25. Was case referred to medical		00.00	24a. Was a autops perform 1 \( \text{Yes} \)	y prior to completion of cause of death? 2 □No 1 □Yes 2 □No
₹	rslcian: s certific lirector,	o Be	examiner?	1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	Home 5 Reside	ence 6 Other (Specify)
on of	nding Phys th. : After this funeral dir	tion: T		Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at		ow injury occurred
Divisi	pital or Attendous after death ours after death leral Directors filled in by the f	Certification: To	a Tariti G Could not be	Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, ,, State)
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	(Check only 2 Medical Examiner: O	To the best of my knowledge, dean the basis of examination and/or d manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier		29c. License number		9d. Date signed (Month, Day, Year)
			10		00058	410	6/10/10
	, , , ~	ĺ	30. Name and address of person who complete	d cause of death (Item 23a) (Type	e, Print)	The Park	6/10/10 y up 2/80 L
	Of ET	20	31. Date filed (Mobile Days Year)	32. Registrar's Signature	T 113) SF	1000	y w 0180 C
	Sta Registra		31. Date filed (MOJURY1Year) 2010	Cerus B. Do	arked.		/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year James M. Edwards Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) NC 1 🗷 M 2 🗆 F Hours Min Dec. 16, 1931 Director 78 238-48-1676 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro 1 X Yes 2 No Maryland| Prince George's 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 17016 Fairway View Lane 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married **Black** If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 - Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Printer Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James A. Edwards Margaret Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Kenny Edwards/ Son 17016 Fairway View Lane Upper Marlboro, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place, Maryland 1 Burial 2 Cremation 3 Removal from State 10, 4 Donation 5 Other (Specify) Cheltenham, Maryland Veterans Cemetery Sig ture of Funeral Service Li 22. Name and Address of Facility Stewart Funeral Home, 4001 Washington, DC 20019 Benning Road NE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ARYNGE Medical Due to (or as a consequence of) Examiner EUNAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician hed for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an cate has t performe After this certificate funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XVo ျှ 1 Copatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) thin 24 hours after de the Funeral Directo Impleted filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number MDD 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar mDo

31. Date filed (Month, Day, Year)

JUN 1-1 2010

7500 Hanover Parkway, Suito WA, Greenbelt, MD. 20770

10-04462	Please Tv	pe or Print i	n Black Indelib	le In	k. Ensure	All Cop	ies Are L	egib	le.		
Benito Silva			and / Departmer					Ŭ	26	10	9834
	1- For State Registrar		Certificat	e of	Death			Reg. N	the total		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Physician/	1. Decedent's Name (First, Mic	ldle,Last)					2. Date of D				3. Time of Death
Medical Examiner	Benito Silv	a-Espino:	za				June 12	Da , 2010			1145 hrs
)	4a. Facility Name (if not institu	tion, give street and n	ımber)	4	b. City, Town, or L	ocation of Dea	th		4c. County o	f Death	
"	Atlantic General Hos	pital			Berlin				Worceste	er	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	ay)	If Under 1 Year	If Under 24H	rs. 8. Date of	Birth(M	M/DD/YYYY)	9. Birti	hplace (State or
Director	218-19-5929	1XM 2 F	48	Yrs.	Months Days	Hours M	5-14	1-1	962	Cou	Mexico
	Usual Residence of Decedent										
any	10a. State 10b. Count	у	10c. City, Town or	Locatio	on						10d. Inside City Limits
and I show ince.	MD Wor	cester	Bishopv	ill	.e						1 Yes 2 No
1aryt 28a-1 at 6	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wh	at Coun	try?
h the Maryland 3a or 28a-f sh otified at onco	9731 Hotel	Road			21813			USZ	Α		
ufter death with the Maryland I", or items 23a or 28a-f show mer must be notified at once. y Funeral Director	11. Marital Status 1 Never Married 2	Married 12. Was De Armed F			Decedent of Hisp s, specify Cuban,			No-	14. Race White		ean Indian, Black,
ufter d	3 Widowed 4 X	ivorced If Yes, Give Yes		1🗶	Yes 2 No	specify: Me:	xican		Specify:	Mex	ican

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, MD 21215-0036

Physiciai /Medica Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

#14-MCGNICO

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4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
Atlantic General Hospital	Berlin	Worcester		
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Bit Months Days Hours Min.	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign		
218-19-5929 1KM 2 F 48	rs. Moritis Days Hours Will. 5-14	-1962 Foreign CouMexico		
Usual Residence of Decedent		10d, Inside City Limits		
10a. State 10b. County 10c. City, Town or Loca		1 Yes 2 X No		
MD Worcester Bishopvil				
10e. Street and Number	10f. Zip Code	l0g. Citizen of What Country?		
9731 Hotel Road	····	USA		
	Vas Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
3 Widowed 4 X Divorced If Yes, Give Year or Dates:	Yes 2 No specify: Mexican	Specify: Mexican		
	ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry		
Elementary/Secondary (0-12) College (1-4 or 5+)				
	-Employed	Retail Store		
17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,			
Armando Silva Obledo  19a. Informant's Name/Relationship (Type Baughter 19b. Mailin	Maria Isabel			
	A			
20a Method of Disposition 20b Place of Disposition	5th St, SW, Apt. 1, position (Name of cemetery, Date	20c. Location - City or Town, State		
1 Burial 2 Cremation 3 Removal from State crematory or c	other place LLC			
Donation 5 Other Specify: Direct	Crematory, 6-18-2010	Dover, DE		
	amaia dailb	Isabella St. ary, MD 21801		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter		est, shock, or heart Approximate Interval		
W at allow - Technology	thanol Intoxication	Between Onset and Death		
100				
or condition resulting in death)  Due to (or as a consequence of):				
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Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
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State Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

**Assistant Medical Examiner** 

32. Registrar's Signature

Ana Rubio MD.

31. Date filed (Month, Day, Year)

JUN 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Physician/ ElmoRE 1709M FRANCES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICAIO MEDICAL Center 54/15 bURY Peninsula REGIONAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country MARY 19NG Months 1 M 2 K 68 Director -42-75 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Mary ANd Alisburg 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2180 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes
If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☒ No Health and Mental Hygiene. tem 27 is marked other than "natural", Specify: BJACK 3 ⋈Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) )omestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blake MADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ( 503 21801 Aylor Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ma HEDRON 4 Donation 5 Other (Specify) permit. { Signature of Funeral Service Lice 22. Name and Address of Facility FUNERA EWAR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Inflactonial Physician/ Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ner function Sequentially list conditions, Due or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Luctive Pulmoran attending physician and for use as the burial-transit COPD the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Coronary Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after feath.

To the Funeral Director: After this certificate has tompleted filled in by the funeral director, page 2 s autopsy performed Yes 2 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XNatural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 re and title of certifier 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) D54127 6 WD

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Power

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 5, 2010 1:30  $P^M$ ARTHUR BEN GASTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MANOR CARE NURSING HOME LARGO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 8/13/1961 Washington, DC Director 48 579-90-2488 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 □ No District Heights Maryland Prince George's 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code ō item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 7109 Chapparal Drive 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Force Black, White, etc. Ď 1 Never Married 2 X Married Yes Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Maintenance Worker Supervisor National Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Corrie Fowler Walter Gaston and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Deirdre Gaston / Wife 7109 Chapparal Drive District heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/11/2010 Harmony Memorial Landover, Maryland 21. Sign run of Funeral Service Lice see 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike forestville, Maryland 20747 23a. Part 1 Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Lift only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) RECURRENT STROKE Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam anding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atte in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown sate has been signed by the page 2 should be detached 1 ☐ Yes 2 L 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsy death? 1 Tyes 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 💆 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature title of certific 6-9-2010 D 51520 pleted cause of death (Item 23a) (Type, Print) Birham Pishdad 1328 Southern Ave. SE Washington, DC 20032 31. Date filed (Month, Day, Yea JUN 1 1 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 8:00 AM Karen Arlene Gish Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month Day, Year) 956 1 □ M 2 💢 53 Aug Maryland 219-66-1633 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland 1 ☐ Yes 2 X No Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21713 8338 Mountain Laurel Road U.S.A. or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Manager Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Everley Ε. Ingram Joyce Arlene Mvers 1 and 2 should bot Health and Melitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven A. Gish / Husband 8338 Mountain Laurel Road Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Samples Manor Cemetery 06-16-2010 4 Donation 5 Other (Specify) Sharpsburg, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike Boonsboro, MD 21713 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Part I. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to lot as a consequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician ai as the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No ō Day Year Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by >ancy to poria 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tyes 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Physicia		State Registrar Amend#7. Per  1. Decedent's Name (First, Middle,		Cen	ificate of L	Jeath	2. Date of De	eath	3. Time of Death
grand .	Medic Examin Funeral Director		4a. Facility Name (if not institution, gas 2005) 115 Con 5. Social Security Number 1613	Advenus	st birthday)	4b. City, Town, or Takom If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	4c, County of	
		ector	Usual Residence of Decedent  10a. State  10b. County		Town or Loca		asan	,	19.501	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the M is 23a or 28 nust be not	Funeral Director	10e. Street and Number	st Avenue		10f. Zip Code	743		10g. Citizen of Wha	100/2011
9003	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if the 27 is marked other than "natural", or items 23a or 28a-f show it litem 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 Marver Married 2  Marrie 3  Widowed 4  Divorced	If Yes, Give Year or Dates. ARM	ny 1[	☐ Yes 2. 1 No	Specify:	pecify Yes or No- to Rican, etc.)	14. Race - , Black, \ Specify:	American Indian, Vhite, etc. 312.CK
21215-0036	l within 72 ho /giene. ner than "na t, the Medio	e Completed by	15. Decedent' (Specify only highest Elementary/Seconday (0-12)		(Give kir life. DO	nt's Usual Occup nd of work done o NOT use retired)	during most of wo	rking	Public 348	School
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Baltimore,	permit. Page 1 Department of Important: If it any injury or conce.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spot 21. Sign furest Fuger S		Carme1	tion (Name of Latory or other place  Cemeter  Name and Address	y July	Date Unk.	in lone	rail tome
F	nysician Medical	725	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aS' (	eps	the mode of dying	g, such as cardiad		_	Approximate Interval Between Onset and Death
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. Box 68760	to the postfall or Attending Prysician: The law requires that the death certificate be within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director, page 2.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of pregnanc  1  Live Birth 2 Fetal of 4 Pregnant at time of dead	death 3 🗌 E	Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
Division of Vital Records, P.O.	equires that the sen signed bould be deta	þ	Part II. Other significant conditions  Acute	1	ting in the unc	0	en in Part I.			e to the cause of death?
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/ita	/sicra	To Be	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	Hospital:	D/Outpotiont	Otho	ace of Death (Che			
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	vith:		29b. Signature and title of certifier			29c. License	number		29d. Date signed (M	onth, Day, Year)
R			30. Name and address of person who	completed cause of death (Item 23	3a) (Type, Prin	t) TA	Haira	- 14 AT 20003	tueso	
	Stat Registra	•	31. Date filed (Month, Day, Year)  JUN 1 0 2010	32. Registra's Signatur	west .				•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 3, 2010 1202 Michelle Hill-Parker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Hours Min. 579-90-1196 Yrs **Director** 50 DC Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Prince George's Capitol Heights Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 United States 7239 Joplin Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. ģ 1 Never Married 2 X Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: B1ack Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Clothing Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ၉ Albert Hill Gardenia Hawkins and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7239 Joplin Street Capitol Heights, Md. Gardenia Hill/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 12, ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. ture of Funeral Service Lice 4001 Benning Road NE Washington, DC 20019 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause operach line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မ Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) nours after death.

neral Director: After this ifilled in by the funeral di this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 D Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

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person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year  $J_{une}^{Month}$  9, 2010 10:03 P M Erika Hatasukireishiawase Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In vrs. last birthday) (Month, Day, Days Hours 1 □ M 2 🔀 F 1962 **Director** 579-04-6631 47 Peru Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 😾 No MD Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20874 USA 18815 Sparkling Water Drive #A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1

Yes 2 □ No Specify Specify: "natural" 3 Widowed 4 Divorced Latino Peruvian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postmaster Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Zoila Cancino Mariono Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18815 Sparkling Water Drive #A Germantown, MD 20874 Alex Schwing/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 06/11/10 Woodbine, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licens 23a. Part 1. Enter the delease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate

Approximate Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Respiratory Arrest Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Vasculitis this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Vear Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2X No 1 Yes 2 No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XNo မှ 1 🔲 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medica Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifier 29c. License number

State Registrar egistrar's Signature

1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nooshin Farr, M.D.

31. Date filed (Month Par Year) 1 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bertha Hawkins June 2010 8:35 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 2062 Forest Drive Annapolis Arunde1 Anne 8. Date of Birth (Month, Day, Feb 3 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 9 1 8 1 □ M 2 🔀 F 92 Yrs. 217-18-0905 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 27 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 2062 Forest Drive 21401 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or Hommon any injury or other trainment. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: Specify: Black 3 □ Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crownsville Hospital 7th 0 <u>Direct Care Aide</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Richard Woodard <u>Florence Chase</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2062 Forest Drive Carol Sellman(Daughter) Annapolis, Md. 21401 20b. Place of Disposition (Name of cametery crematory of other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-10-10 U.M. Church Arnold, Md. 4 Donation 5 Other (Specify) Membrame Reading of Eacility ons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Ravy B, Keese MOCH 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eNile **Physician** ew wear dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner norexim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed?
Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation ieral Director: A 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1209A DR. Nancy RIVERA-KING Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 092010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in Black State of Maryland / De	epartment of	Health	n and Mei	•	_	
			Certificate of	Death			Reg. No.	9842
Physician Medica		1. Decedent's Name (First, Middle, Last) Hobert Hogue			J	Date of Dea Month Une	Day 2010	3. Time of Death 3:50 A M
Examine	er	4a. Facility Name (If not institution, give street and number)  Crofton Convalescent & Rehab	4b. City, Town, C				4c. County of Dea	Arunde1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 1 M 2 □ F 94 Yr.	Months Days	If Und Hours	er 24 Hrs. 8. Min. S ∈	Date of Birt (Month, Day P		rthplace (State or Foreign ountry) inia
/land f show ed at	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town o						10d. Inside City Limits
the Mary or 28a-	Funeral Director	Maryland Anne Arundel Anna  10e. Street and Number	polis 10f. Zip Code	<u></u>	-		10g. Citizen of What C	1 ☐ Yes 2 🕅 No country?
th with	nera	214 Bowie Ave	214				USA	
or i	É	1 ☐ Never Married 2 ☐ Married    1 ☐ Yes 2 M No   If Yes, Give	<ol> <li>Was Decedent of H If Yes, specify Cub</li> <li>1 ☐ Yes 2 X No</li> </ol>	an, Mexic	can, Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Whi Specify:	
2 hours	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupive kind of work done	during me	ost of working		16b. Kind of Business	
vithin 7 jene.		Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired, ment Fin:		r		Construc	ction Co.
filed wall Hyg		17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (Fi	, ,	Maiden Surname)	
uld be I Ment narke	욘	Lee W. Hogue			ssie N			
nd 2 shore			lailing Address (Street 53 Carve				r, City or Town, State, 2 1s, Md. 2	
Page 1 ar			isposition (Name of Crematory or other pla ial Park	ce)	Date 6-14-		20c. Location - City of Annapoli	
permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	2W Marne a Ru Adare	Seff t St	Sons	Mort	uary, P.A s, Md. 21	<i>I</i> •
Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition		ng, such a	as cardiac or re			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)  Due to (or as a consequence of):						
uted nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events c.						
be eg	ca	resulting in death) Last  Due to (or as a consequence of):						
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3  Ectopic pregnan 5 Other (specify)	су			23d. Date of d	elivery Day Year
at the de d by the etached		g Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in t	ha undarlying cause g	iven in Pa	ort I	220 Did to	obacco use contribute t	to the sauce of death?
quires than signed and be do	ed by	Tattii. Outer significant conditions contributing to death out not resulting in a	The differrying cause g	IVCII MIT G		1 🗆 1	1/	Probably 4 Unknown
ne law rec e has bea age 2 sho	Completed						prior to rmed? prior to death?	
ian: Th rtificat rtor, pe	Be C	25. Was case referred to medical examiner?	26. P	lace of De	eath (Check oni		2 <b>Z</b> No 1 1 Ye	es 2 No
physical this ce	욘	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		4 💢			lence 6  Other (Spe	cify)
ath. r: After t	Certificate:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident	ry wor	ry at k? Yes 2		. Describe h	ow injury occurred	
al or Atte s after de l Directe d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		28f.	Location (S City or Tow	treet and Number or Ri n, State)	ıral Route Number,
e Hospite 24 hours e Funera leted fille	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, de-	vestigation, in my opini	ion, death	occurred at the	time, date a	nd place, and due to the	cause(s) and manner state
To the within To the comp		29b. Signature and the of certifier	OGo Licens				od i Deteriored (Man	th Day Vond
DN3		30. Name and address of person who completed cause of death (Item 23a) (Type 2 2 5 E	pe Print) Conco	14.	-11	rof	ton, me	21114
State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	6- 40	1/3			/	-
Registra	r	JUN 0 9 2010   Senus B.	gara					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** isbur icomico ursina enter Ja. If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Min. Maryland Director or 28a-f show notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho ant; If item 27 is marked other than "natural", or items 23a or 28a-f sho unty or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4745 Cardinal Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. Army Specify: white 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) instructor computer science Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise K. Williams 2 Percy Hotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4745 Cardinal Dr., Salisbury, MD 21804 Sonya Hotton/daughter Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/7/2010 Salisbury Crematory Salisbury, MD Signature of Funeral Service Lice HOTTOWay Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 34 Ears 1500D disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** LIVER CIRRHUSIS 1 year Sequentially list conditions Examiner if any, leading to immediate cause. Enter or serving Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC ODSTRUCTIVE LUNG DISTASE and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completed filled in by the funeral director, page 2 should be 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 21 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 10 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M D051359 3rd 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

NATESAN

32 Registrar's Signatur

1415-5. DIVISION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fh g905 7-23-10 vt State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 9,2010 Hannan Charles Н. 3:33A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death 7407 Market Street Wicomico Willards 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1923 (Month, Pay, Year) Oct 4, 1921 9. Birthplace (State or Foreign Country)
Pennsylvania **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. 86 Director 154-18-7661 Oct. Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ₹ Yes 2 ☐ No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21874 7407 Market Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No 1942-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 🖾 Widowed 4 🗆 Divorced 1943 Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Manufacturing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hannan Joseph A1ma Helgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Brechemin- daughter P.O. Box 224 Willards, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Crematory of Delmarva 6/10/2010 | Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E Main St. Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIMPHOSIS LIVER Physiciani ANVANCEN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AMETOS HELLITUS YPE 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown MERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred // medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 1 🗌 Yes 2 M No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) . Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tyes 2 🗌 No Completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20058662 10 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMC-870 CHESIMETRICE MR. CAMBRINGE, MD 216/

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 10

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month June Margaret Ann Hudson 2010 4,22 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex If Under 1 Year 7. Age (In vrs. last birthday) Funeral Days Min. Dec Mosth, Day 98274 1 1 M 2 X 85 Washington, DC 173-24-7040 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 23a or 28a-f 1 Yes 2 X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 USA 332 Magnolia Avenue or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even ည Joseph Nathan Arthur Sr. Margaret Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Richard Hudson Sr. - husband 332 Magnolia Avenue; Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) any inj once, Sign ture Funeral Service L 22 State Anatomy Board; 655 West Baltimore Street Maryland 21201 Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burialby Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death been signed by the should be detached a I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital 1 Yes 2 40 잍 Impatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) MDD 16428 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) 300 W Frederick, MD filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		, , , , , , , , , , , , , , , , , , ,	Cer	tificate of	Death		Reg. No.			
	Physicia	an	1. Decedent's Name (First, Middle, L	•					2. Date of De Month	Day	Year	3. Time of I	
	/Medic	al	Jean Hatzistefar		harl		4b. City, Town, o	Logation of D	May	16	2010 County of Death	2:22	A <sup>M</sup>
	Examin	er	4 Rene Avenue  Baltimore						outly of Beath	,			
I	Funeral		,	Sex 7	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Date of July 1	rth ay, Year)	9. Birth	nplace (State or untry)unk	r Foreign
	Director		216-34-6603 Usual Residence of Decedent		71	115.			July 1	1, 19	38		
	yland how		10a. State 10b. County			, Town or Lo						10d. Inside Cit	
	e Mai	ctol	MD		Ва	altimo:						1 Ā Yes	2 No
	with th	Funeral Director	10e. Street and Number				10f. Zip Code 21225			10g. Citize	en of What Cou	untry?	
	ns 23	neral	4 Rene Avenue	12. Was Deced		S. 13. \		lispanic Origin	? (Specify Ye's or No uerto Rican, etc.)		4. Race - Amer		
õ	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evandher must be notified at		1 Never Married 2 Married	Armed Ford 1 ∐Yes 2 If Yes, Give	2 X No		f Yes, specify Cuba 1 □Yes 2⊠ No		uerto Rican, etc.)	Black, White, etc.  Specify: White			
215-0036	hours tural",	ed by	3 Widowed 4 Divorced	Year or Da	tes:		dent's Usual Occup				d of Business/Ir		
5	in 72 n "nat	plete	15. Decedent's I		4075.)	(Give	kind of work done DO NOT use retired	during most of	working	TOD. KITC	1 of Business/ii	ridusity will	
7	d with giene er tha	Completed	Elementary/Secondary (0-12) unk	College (1-4	nk								
and	ges 1 and 2 should be filed within 72 hours after death with the Marylan ni of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "dotter Examine must be notified at	Be	17. Father's Name (First, Middle, Las	st) unk				18. Mother's	Name (First, Middle	, Maiden S	urname) unl	k	
Ž	should nd Me mark matic	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address (Street	and Number o	r Rural Route Numb	er. City or	Town, State, Z	ip Code)	
Ma	alth ar 27 Is er trau		Mary King - da			1 .			Ltimore, N				
ore.	les 1 a cof He if item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from S	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Loca	ation - City or T	Town, State	
saltimore,	it. Pag rtmen rtant; njury o		4 □ Donation 5 🛣 Other (Spec	ify) in sta			Name and Address	i i					
n D	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trae		21. Signature it uneral Service Lice	Wade / Ni	rector	St		omy Boa	ard; 655 V	Vest E	3altimo	re Stre	et
ı			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that ca	used the death	n. Do not ent	altimore, er the mode of dyi	Maryla ng, such as car	and 21201 diac or respiratory a	arrest,		Approximate Interval Betv	e veen
40	Physician		Immediate Cause (Final disease or condition		huse	ma						Onset and D	
	/Medical Examiner		resulting in death)		r as a consequ							-	·
		er	Sequentially list conditions, if any, leading to immediate	b	r as a consequ	uence of):							
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Š,	oe exe		resulting in death) Last		r as a consequ	uence of):							
00/00	ficate be executed physician and s the burial-transit	Medical		d									
X O O	ng a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			7			23	3d. Date of deli	very	
ה מ	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 █ No		rth 2□Fetal ant at time of d wn		∃Ectopic pregnand ∃Other <i>(specify)</i> _	;y 			Month	Day Y	'ear
ר ר	hat the d by ti letach	Phy	9 ☐ Unknown  Part II. Other significant conditions			ulting in the u	nderlying cause giv	en in Part I	23e. Did	tobacco usi	e contribute to	the cause of de	eath?
necorus,	uires t 1 signe 1d be c	d by	Tarri, Circi digililocati dell'allero	Contributing to doc		arang in the di	nderlying sacce giv	off iff are is		Yes 2□		obably 4 🗍 U	
၁	sw red s beer s shou	Completed							24a. Was		24b. Were au	topsy findings a	available
ב ב	The Ia ate ha page 2	)om						_	— auto perfe 1 □Yes	ormed?	death?	completion of ca 2 □ No	ause of
N I G	cian: sertific	Be (	25. Was case referred to medical examiner?	112-1			100		Death (Check only				
5	Physical direction	.T	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 In In 28a. Date o	patient 2 🗆	ER/Outpatier 28b. Time of		4 LI Nursii	ng Home 5 Res		Other (Spec	cify)	
VISION OF	th.: After	ation	1 Natural 5 Pending 2 Accident investigation	(Month	n, Day, Year)	Injury	Wor	k? lYes 2 □ No	20d. Describe	now injury	occurred		
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place o	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office			(Street and wn, State)	Number or Ru	ral Route Num	ber,
5	pital o		30a Cartifiar 1 Cartifician 1	Obvinishen To Ale 1	and of my line	uladaa daat	h agguerod at the ti	me date and r	None and due to the	(-)		atoto d	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Medical	29a. Certifier  (Check only one)  1 Certifying F  2 Medical Example:	aminer: On the ba and mann	sis of examina	tion and/or in	vestigation, in my	opinion, death	place, and due to the occurred at the time	, date and p	place, and due	to the cause(s	)
	To th Vithin Comp	Me	29b. Signature and title of certifier	· ·			29c. Licens			4-	signed (Month	. 0	
			1 Whent 13	ut			107	966	O	700	و ۱٦,	2010	
			30. Name and address of person who Robert Dur	1 40	· =	Frt	Deta	Bul.	fimore,	mi	> 21	230	
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture							
	Registr	ar	JUN 2 4 2010	Mune	p. A	aver							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GLORIA **THERESA** JOHNSON June 2010 2207 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours (Month, Day, Yea 579-46-7446 Washington. **Director** 933 76 Jun. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director District of Columbia Washington 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5517 Hunt Place, N.E. 20019 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black. Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private Be Department of Health and Mental Hill Important: If item 27 is marked oth any injury or other traumatic and once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 0'Neil Alfred Longus Marv Forrestia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hunt P1., N.E., Tyler. Joan Daughter 5517 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 06/11/2010 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Harmony Mem'l Park 4 ☐ Donation 5 ☐ Other (Specify) Hyattsville, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funera Service 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Edema disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiomyopathy Ischemic Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a co tience of Breast Carcinoma the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No 1 🗌 Yes 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 A ER/Outpatient 3 I DOA after death. Director: After this uneral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 027650 06/07/2010 ense 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6196 Oxon Hill Rd., #500, Oxon Hill, MD Cynthia Crawford Green, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0112A M Louis E. Jones Medical 4a. Facility Name (if not Institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** REGIONAL Wicom 10 1AU364N If Under 1 Year If Under 24 Ars. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Hours Country) Director -1932214-32-1004 21 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Somerset Princess Anne MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11520 Pine Pole Road 21853 Page 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married Yes 2 No Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working C&W Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Moody Jones Florence White 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11520 Pine Pole Rd. Princess Anne, MD Ruth A Jo 20a. Method of Disposition Jones/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6-8-2010 Venton, MD Trinity UM Cem 22. Name and Address of Facility 917 W. Isabella St. nturo of Europai Sorve 21. Sid any Bennie Smith Salisbury, Funeral Home Salisbury, enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final e, or complications that caused the death. Do not enter Approximate Interval Between Onset and Death est vi Physician/ 0 2 disease or condition resulting in death) Medical Due to (or as pronse pience of) <sup>\*</sup>Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) g Unknown signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours a e Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, D20441 06 inpleted cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Fetto State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Merry **Physician** 10:20 PM Luca 08 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rinerdale PG1 Crescent Cilies Con Cour 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. MIDDLESEX, NC 578-44-1766 89 Director 11/14/1920 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinat must be notlined at 1 Yes 2 □ No Director MD PRINCE GEORGES RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with UNITED STATES 4409 EAST WEST HIGHWAY 20737 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 \_\_Yes \_\_Zh\_\_ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify Specify: BLACK 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12t LICENSE NURSE DEPT. OF PUBLIC HEALTH permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN SMITH NONIE FINCH ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD LUCAS /son 7910 GREENBURY DRIVE GREENBELT, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2010 OLIVET WASHINGTON, DC MT.21. Significant Funeral Service Ligensee 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME LL 3005 12th ST. NE WASHINGTON, DC 20017 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 5 Other (specify) P.O. the ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 2 🗵 1 Tes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Uursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Continuous of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) Certifie D0064208 6-10-10

East west Huy, Rueidale MD
20737. 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar Husain

31. Date filed (Month, Day, Year)

JUN 1 1 2010

M.D

32. Registrar's Signature

4409

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Dav **Physician** 2010 1300 M 06 Alice orene /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sabil lasville Frederick 16429 Foxville If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV 3, 1932 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country)

 Country) **Funeral** Hours Days 1 □ M 2 🗓 F 77 229-36-5584 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Madical Exprandur must be notified at 1 ☐ Yes 2 录No Director MD Harford Edgewood 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16429 Foxville Deerfield Road 21780 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) Hygiene. s 1 and 2 should be filed wire fleath and Mental Hygier Item 27 is marked other them 27 is marked other them 27 is marked other them 15 is marked othe 17. Father's Name (First, Middle, Last)unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau Becky Sherman - friend 16429 Foxville Deerfield Road; Frederick, MD 21780 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) <sup>22</sup> State Anatomy Board; 655 West Baltimore Street 21. Signature of Funeral Se vi ector Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy Hospital or Attending Physician: The certificate 2 XINo 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation death. 1 □Yes 2 □ No hours after death, uneral Director: / d ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JUN 24 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Frayre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $18^{\text{Day}}$ Physician/ Month 2010 Jamie Suzanne Mears-Fitzpatrick June 3:14 A.™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2758 Lynn Street Frederick Frederick Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days 1 □ M 2**V**□ F Hours Min. (Month, Day, Year) Washington, 52 215-72-0905 Director Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 ☐ Yes 2v No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2758 Lynn street 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Anaylist Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Mears Jeanette Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Fitzpatrick / Husband 2758 Lynn Street, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery June 23, 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland . Signature of Funeral Service Lic Reeney & Basford F.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset an Death Immediate Cause (Final Physician. pirato disease or condition resulting in death) Medical consequence of Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospitalior Attending Physician: The law requires that the death certificate be executed within 24 hours: flor death. cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 18, 2010 1 Lanan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ms Ste 200 Thoma Johnson Date filed (Month, Day, Year) State Registrar IIIN 2.4 2010 DHMH 17 Rev 7/2009

DIF

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland	/ Department of He	alth and Mental Hygiene
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		•	For State Registrar	State of Marylan	•	artment of <i>tificate c</i>			eg. No.	10000
	Physici	an	1. Decedent's Name (First, Middle, Last)  CARY JAMES	MEILER	т			2. Date of Deat Month JUNE	17 2016	3. Time of Death 2:30P M
7	/Medic Examin	al	CARY JAMES  4a. Facility Name (If not institution, give si			4b. City, Town	n, or Location of Death		4c. County of D	
	LAdillii	CI	GENESIS LA PLAT	TA CENTER			LATA		CHAR	
	Funeral Director		5. Social Security Number 6. Sex 219-72-6532	7. Age (In yrs. 5		If Under 1 Ye Months Da		8. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					MAY 9,	1950 IM.	INNESOTA
	lanylar show	J.	MD CHARLES		y, Town or Lo ALDOR I					10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-1	Director	10e. Street and Number	11	712DOK	10f. Zip Cod	е	1	log. Citizen of What	Country?
	th with		1121 HERITAGE E	PLACE		206			U.S.	
136	urs after dea II', or Items Stambour m	by Funeral	11. Marital Status 1  1   1   Never Married 2   Married 3   Widowed 4   Divorced 1	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 250 No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto No Specify:	pecify Yes or No- p Rican, etc.)	Bfack, W	merican fndian, /hite, etc.
1215-0036	filed within 72 hours after death with the Maryland Hybjene. Ither than "natural", or Items 23e or 28e-f show int, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	completed) College (1-4or 5+)	(Give life, L		ne during most of won tired)		16b. Kind of Busine	
Z D		e Co	17. Father's Name (First, Middle, Last)	2	FOOD	ENTRE	PRENEUR 18. Mother's Nam		RESTAUR? Maiden Sumame)	ANT
<u>la</u>	should be bd Mental marked o	To B	JOHN J. MEILER	RT.			ALICE	M. KLA	VER	
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type JOHN J. MEILERI			•	eet and Number or Au			
a)	teall m 2		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	ERS FARM	Date	20c. Location - City	
Ē	Pages nent of int: If I		1 ☐ Burial 2 <b>X □</b> Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other REMATO	100111	_	ALEXANDE	RIA. VA
Baltimore,	permit. Pages 1 Department of H Important: If its any Injury or ot once.		21. Signature of Funeral Service License	°\$55 MOO			dress of Facility RA	YMOND F	'UNL.SER'	VICE, P.A. ,MD 20646
1	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on fmmediate Cause (Final disease or condition	e cause on each line.	th. Do not ent		dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death MONIFIES
	/Medical Examiner		resulting in death)  Sequentially list conditions.	Due to (or as a conseq	AID	5				YRS
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consec						
8760,	cate be executed physicien and the burial-transit	dical E	d d	Due to (or as a consec	quence or):					
9			IF FEMALE:	3c. If yes, outcome of pregn	ancy				23d. Date of	delivery
.О. Вох	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ifdeath 3	Ectopic pregna Other (specify			Month	Day Year
rds, P.	taw requires thet the de as been signed by the a 2 should be detached f	δ	Part ff. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	given in Part I.	1	bacco use contribul 'es 2 ☐ No 3 ☐	te to the cause of death?  Probably 4 Unknown
I Records,	The ste h page	Completed						24a. Was a autop perfor	sy prior	
Z z	sician: certific rector,	o Be	25. Was case referred to medical examiner?	ospitaf:	155/6		Othor	th (Check only or		0 - 11
Division of Vital	ing Phy Viter this uneral d	1-1	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c.	njury at Work?  1 Yes 2 No		dence 6 Other (s	<i>Бреспу)</i>
Divisi	2 # E C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	reet, factory, off	ice	28f. Location (S City or Tow	Street and Number o vn, State)	or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (		ician: To the best of my knier: On the basis of examinated and manner stated.						
	To the within 2 To the comple	¥	29b. Signature and title of certifier	n /			ense number		29d. Date signed (M	
,			30. Name and address of parsein who co	mpleted cause of death (Ite	m 23a) /T	Print\	000601	18	6/19/	1010
			RICHAS FILLY	17064	FERRY	Doce	(Pd, 1	King 6	Bons 13	7010 VA 92485
ī	Sta Regist		31. Date filed (Month Pay 2 ear) 2011	32 Registrar's Sign	ature de	and I		,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dotty Lou Mayle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Regional Med. Ctr. Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Days 1 🗆 M 2 🗓 F Hours Months Min. **Director** 213-80-9442 64 Pierce Oct WV Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14300 Jared Drive, Lot 0 21502 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Richard Henry Rhodes Stella Mae Paugh or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Patricia P. Sisler/Daughter 14300 Jared Drive, Lot 0 Cumberland, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 20 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalbaugh Cemetery 2010 Elk Garden, WV 21. Signature of Funeral Service Licen 22. Name and Address of Facility Smith Funeral Home Dum 85 S. Main Street Kevser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ANOXIC disease or condition resulting in death) ENCEPHALOPATHY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARREST, CHF COPD 1 ☐ Yes 2 ☐ No 3 Ø Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy perform death? certificate Yes 2X No 1 ☐ Yes 2 🔯 No the Hospital or Attending Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Within 24 hours after deau..

To the Funeral Director: After this of ᅆ 1 🕅 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aulan. MD D0065702 06 16/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVIK. AIYER WMRMC-WMHS Willowbrook Road Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decement's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day 2343M IUNE Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NNMPO Loen de 1 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 1 M 2 □ F Months Oct. 27 Year) 1961 Min DC 48 Director 578-88-4162 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumafte event, the Medical Examiner must be notified at any injuy or other traumafte event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 United States 1121-5th Street NE Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes African 1 ☐ Yes 2 🔀 No Completed 3 Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Carrier Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillie Robinson Paul C. Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 Cindywoods Ave. NC 28216 Wynsday P. Jenkins/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State June Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln Memorial 2010 Signature of Funeral Service Lid 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC 4001 23a. Part 1. Exter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 104 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last physician s the burial rt-ONSION Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Por Year Month Day Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 2 🗌 No 2 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, 10 06054 MO cause of death (Item 23a) (Type, Print) Name and address of person who complete

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's

JUN 1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 June 1140 6, A M Barbara Mosley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Year) 1937 Virginia 72 Director Nov. 224-48-8812 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Glenarden Prince George's Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a o Funeral 20706 United States 3211 West Glenreed Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 3 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔼 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Government Claims Examiner 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown Flossie Lovelace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20706 3211 West Glenreed Court Glenarden, Md. Regina Wiley/ Daughter Date 16, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town State cemeters, crematory or other place)
Maryland
Veterans Cemeter 1 X Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland emetery nature of Fune I Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Road NE Washington, DC Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Examiner Brain Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this confidence. Cause (Disease or linjury that initiated events <u>Seizures</u> burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ise 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🔼 No 2 X 1 🗌 Yes Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

31. Date filed (Month, Day, Year) State 2010 Registrar

3

29b. Signature and title of certifier

Kanwaljit Kaur

1500 Forest Glen Road MD 'Nagi, 32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

M

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

0

20910

6

Silver Spring, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2010 1:45 P M Gaye Monaghan June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1201 East-West Highway Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** July 12, 1937 Washington, DC 1 M 2 X F Months Days Hours 577-52-0689 Director 72 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1201 East-West Highway 20910 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married \$ ☐ Yes 2 ☐ Yoo Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Counselor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Winter Kina Moore Harriet Williams Gaye Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Brigid Monaghan/daughter 1729 Overlook Drive Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/11/2010 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Lice atens M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ Cerebral Vascular Accident disease or condition Medical resulting in death) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 X 9 Unknown the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign. 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 XNo 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 24 hours after death.

E Funeral Director: Aff Accident 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the pasis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D34472 June 9, 2010 s of person who completed cause of death (It 10400 Condectlicut Avenue Suite #206 Kensington, MD 20895

Registrar DHMH 17 Rev 7/2009

State

Lynne D. Diggs,

31. Date filed (Month, Day, Year)

M.D.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

**ORIGINAL** 

32. Fegistrar's Signatur

welled.

10-04622 David Wayne Minnick

Please amend #5	Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	38	5
4-	Control of Double		

·		1- For State Certificate of Registrar	Death	Reg	. No.	
Physicia Andical Exami	an/	Decedent's Name (First, Middle,Last)	-	2. Date of Death Month	Day Year	3. Time of Death 1840 hrs
"^qicai Examii			b. City, Town, or Location of De	June 18, 20	4c. County of Death	1040 1113
		Washington County Hospital	Hagerstown		Washington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign	1
Director		212-80-8118 1∑M 2□F 46 Yrs.		Sept 1	3, 1963 <sup>cou</sup>	<sup>ntry)</sup> Maryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
	٦	Maryland Washington Boonsbor	<b>:</b> 0			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?
ith the Maryland 23a or 28a-f sho notified at once.		19831 Harmony Hill Lane	21713		S.A.	
ath will items	Funeral	1 Never Married 2 Married Armed Forces? If Ye	s Decedent of Hispanic Origin? ( es, specify Cuban, Mexican, Pue		14. Race - Americ White, etc.	an Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		1 Yes 2 No 3 Widowed 4 X Divorced or Dates:	Yes 2 X No specify:		Specify: Whi	te
iours a	od be	15 B 1 B 5 B 1 C 10 C 11 B 1 B 1 B 1 B 1 B 1 B 1 B 1 B 1 B	's Usual Occupation (Give kind ost of working life, DO NOT use		16b. Kind of Business/In	dustry
5-0036 led within 72 hours a Lygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12)			Manufactur	rino
5-00; ed with fygiene other t	Ë	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		6
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	William H. Minnick		Pauline C		
ID 21 ! should I and Mer 27 is man	٤		Address (Street and Number of Harmony Hill			
Z charth a Z Z marth	ŀ	20a. Method of Disposition 20b. Place of Disposit	tion (Name of cemetery,		20c. Location - City or T	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or oth Mt . Zion (	· · ·	-23-2010	Roonshore	, Maryland
Baltimor permit. Pages Department of Important: If	1	4 Bonation 6 Carlot opening.			fer Funeral	
ij il ga	5 0	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	06 Old Nationa	l Pike B	oonsboro. M	
Physician	5 %	failure. List only one cause on each light. Cardiac Arrhythm	ia due to Left	Ventricul	ar.	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Fibrosis and dil:  Due to (or as a consequence of):	atation			
		Sequentially list conditions, b.  If any leading to immediate  Due to (or as a consequence bry				
	Examiner	rause. Enter Underlying Cause (Disease or injury that initiated				
ed nsit	Exar	events resulting in death) Last Due to (or as a consequence of):				
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760, icate be exe	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Sox 687 leath certific e attending   for use as t	ian/	past 12 months?  1 Live birth 2 Fet 4 Pregnant at time of death 5 Oth	al death 3Ectopic preserrer (Specify)	gnancy	Month Da	ay Year
Box 687 e death certificather attending led for use as the	Physician	1 Yes 2 No 9 Unknown				
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IS, P quires t en sign			<u> </u>	24a. Was an		opsy findings available
Cords, law requir has been s	Completed			autopsy perform	prior to co led? death?	mpletion of cause of
tal Rec		25. Was case referred to medical	26.Place of Death (Che	1 ✓ Yes 2	No 1 ✓ Yes	2 No
Vital F hysician: this certifu	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	045		esidence 6 Other:	
of ing Ph After t		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of In		28d. Describe ho	w injury occurred	
Sion Attend death. sctor:	catic	Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, stree	1 Yes 2 No	29f Location (Str	reet and Number or Run	al Poute Number City
Division of Vital Records, pital or Attending Physician: The law require ours after death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could not be determined (Specify)	t, factory, office building, etc.	or Town, Sta		ar route Humber, Only
E 6 6 Pi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr	ed at the time, date and place, a	and due to the cause	s) and manner as state	d.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigati and manner stated.  29b. Signature and title of certifier	on, in my opinion, death occurre		nd place, and due to the  29d. Date signed (Mon.	
	2	290. Signature and title of certifier	O.C.M.E.		June 19, 2010	iri, Day, rear)
	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
M-0			enn Street, Baltimore, M	ID 21201		
St Regist	ate		and			
DHMH 17 Rev 1/2	_	OCME ORIGINAL	_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2:10 PM 2010 June MALINDA BEATRICE NEALE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Regional Hospital aurel Laure Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Hours Days Min. 1 □ M 2 1 F Yrs. 2/16/1935 **Director** 577-46-1894 75 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh rrottfied 1XYes 2 No Directo Silver Spring Maryland | Montgomery Pages 1 and 2 should be filed within 72 hours after death with the inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, It a Medical Examinat must be a 12801 Columbia Pike # 201 20904 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify: Completed by Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Assistant</u> Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Soloman Hart Amanda Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earle Neale / Son 10101 Texas Terrace, Largo Maryland 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2010 Harmony Memorial Landover, Maryland 21. Signatu of Funeral Service Licens 22. Name and Address of FacilityPope Funeral Homes, P.A. MORANT 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Phier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic **Physician** Shoc /Medical Due to (or as a consequence of): Examiner Diverticular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 No 1 □Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the

31. Date filed (Month, Day, Year) JUN 1 1 2010

Abdul Tak, MD

29b. Signature and title of certifier

Prince George's County 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D60936

29d. Date signed (Month, Day, Year)

7300 Van Dusen Road

Laurel, MD

June 6, 2010

			1 - State Registrar		Certificate of Death Reg. No.							
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of D Month					
	Physici /Medio		HANNAH MARIE	PERRELL				JUNE	10, 201	10	11:10 PM	
-	Examir		4a. Facility Name (If not institution, give street and number) AUTUMN ASSISTED LIVING			4b. City, Town, or HAGER	W	4c. County of Death WASHINGTON				
I	Funeral Director		202 20 7 100	x	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth av Year) 921	9. Birthplace (State or Foreign WEST VIRGINIA			
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural; or flems 23a or 28a-1 show any injury or other traumatic event. In a Medical Examinar must be notified at once.		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				1	IOd. Inside City Limits	
		Director				MARTINSBURG			40 07	1 Tyes 2 No		
		ral Dir	10e. Street and Number 12805 APPLE HARVEST DRIVE 10f. Zip Code 25403 10g. Citizen of What Country? USA									
		by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ŀ	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	Spec	ace - Americ lack, White, cify: Wh		
2		etec	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occup kind of work done	during most of wor	rking	16b. Kind of	Business/In	dustry	
imore, Maryland 2		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT use retired HOMEMA	•		(	OWN HOME		
		To Be C	17. Father's Name (First, Middle, Last)  JAMES PRESTON MYERS			18. Mother's Name (First, Middle, Maiden Sumame) PEARL GRACE RING				ame)		
			19a. Informant's Name/Relationship (7)	, ,		g Address (Street: 05 APPLE					WV 25403	
			20a. Method of Disposition XX☐ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)			sition (Name of TEXX 90 of ARD GARDENS	JUNE 20:	14, 10	20c. Location		BURG, WV	
Balt			21. Signature of Funeral Service Licens	reldo	22	Name and Addres	ss of Facility NG ST., MAF	BROWN FU RTINSBURG	NERAL HOM , WV 2540	1E, PO E 12	BOX 821,	
п	he death certificate be executed  Wedical  Whe attending physician and ched for use as the burial-transit	72	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
6			Immediate Cause (Final disease or condition A A D									
			resulting in death)  Due to (or as a consequence of):									
,09		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ	Due to (or as a consequence of):							
			that initiated events	С.								
			resulting in death) Last	Due to (or as a consequ	Due to (or as a consequence of):							
68760		/Medical		0		-						
P.O. Bo		by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year	
	that the part of t		Part II. Other significant conditions co	ntributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?	
rds	The law requires that the death the has been signed by the atter age 2 should be detached for	ed b	Dight malletes tope TI I			Muletian 10			Yes 2 □ No	es 2 No 3 Probably 4 Unknown		
		Certification; To Be Completed	Anem Hop	they willing	Dem	utr		peri	s an 248 opsy ormed?	o. Were auto prior to co death? 1  Yes	ppsy findings available impletion of cause of	
	iician: The l certificate ha rector, page		25. Was case referred to medical examiner?				26. Place of Dea			Α.	STUMM T	
	hys this		1 ☐ Yes 2 ☑ No		1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home				5 ☐ Residence 6 ☐ Other (Specify) PSSISTED UV			
			27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M 1 1 9es 2 No								
JINISI	i Qir		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		me, farm, stro				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Hospita 4 hours Funeral ety filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To tha Hos within 24 h To tha Fur completely	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								Day, Year)	
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			30. Name and address of person who co	In 1 7/12 3	23a) (Type,	: 1				1110	-	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signati	ure 0	MAGE	KSTOW	o mo	211	70		

DHMH 17 Rev 1/2001

State Registrar

JUN 2 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2010 11:25 A M **PRADO** Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CECIL UNION HOSPITAL ELKTON Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Hours (Month, Day, Yea 3 / 9 / 194] Director 222-24-0191 69 DELAWARE Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD KENT GALENA 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 PHELPS AVENUE 21635 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after d Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina on e. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANIEL D. SWIFT ALICE E. FRANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IVY LANE NEW CASTLE, DE 19720 BOGGS/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1/2010 | 0 WILMINGTON, DE 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other Specify SILVERBROOK CEMETERY ice Lice 22. Name and Address of Facility SPICER-MULLIKIN FH 1000 N DUPONT PKY NEW CASTLE, DE 19720 1. Enter the disease, or complicat shock, or heart failure. List only on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line. Immediate Cause (Final Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Asthuer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Conferm and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FFMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ed by the a detached f Yes 2 No g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signe d be 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 1 🗌 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No မ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

10-04451 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shannon Palmer State of Maryland / Department of Health and Mental Hygiene 010 1985 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 12, 2010 Medical Examiner 0623 hrs Shannon Palmore Shannon Palmer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3307 Walters Lane #203 Prince George's Forestville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Min Director 218-08-7113 1 X M 2 F Country) Yrs DC 25 May 4. 1985 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou
injury or other traumatic event, the Medical Examiner must be notified at once. Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4409 Ponds Street NE 20019 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married 1 Yes Specify: Black 3 Widowed If Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Bricklayer Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rainetta D. Palmore David Payne ဥ 19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forestville, Md. 20747 3603 Willow Ridge Court Mary D. Moore/ Grandmother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date June 19. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland Maryland National 2010 Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral rvice 4001 Benning Road NE Washington, DC e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician re. List only one cause on each line. Between Onset and /Medical Death Phencyclidine and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical AMENDED 1 per me g905 7-6-10 yt 23a,27,28a-f, per ME g904 6/30/10 TT XUNPENDED of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Day 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown ģ Unknown n signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy page 2 s performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural subject took PCP & alcohol Division 1 Yes 2 X No Pending To the Funeral Director: Fd 6/12/10 Location (Street and Number or Rural Route Number, City Fd 6:10 am 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Suicide 6 Could not be or Town, State) 3307 Walters Ln # Forestville, MD (Specify) House determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 12, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's signature

Registrar DHMH 17 Rev 1/2001 **OCME 2006** 

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		1-For State Certificate of Death Registrar		eg. No.	ZUII	
Physiciar	1/	Decedent's Name (First, Middle,Last)	Date of Deal     Month		Year	3. Time of Death
Medical Examin	er	Edward Leonard Pauls	June 17, 2	2010		0723 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Mountaindale Rd/ Gambrill Park  Frederick			County of Deat rederick	1
			To not ornic			ab - 1 (Q) - 1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	7		Foreig	thplace (State or gn
Birodoi		232-47-4321 1XM 2F 50 Yrs. World's Day's Hours Will.	July 3	30,	1959 <sup>Co</sup>	ountry) England
a	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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Maryland 28a-f show any d at once.	ᅙ	Maryland Frederick Frederick  10e. Street and Number 10f. Zip Code	T10	Og Citiz	en of What Cou	
or 28	활					,,
vith ti	ᇹ	804 Ivy Way, Apt. 1A 21701  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-		gland 14. Race - Amer	ican Indian, Black,
eath y item	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto			White, etc.	,,
ufter d	<u> </u>	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		5	Specify:	White
ours 2	١٩	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retirements of the complete of the c		16b. Ki	nd of Business/	Industry
6 172 h san "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ea)			
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112 Id be Aenta narke event	e   e	Frederick Pauls Pearl Gr  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R		har Cit.	. or Tour Ctata	Zin Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	-					
and 2 and 2 fealth item 2 trau	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Lo	cation - City or	Town, State
OCE 1 See 1	-	1 Burial 2 X Cremation 3 Removal from State crematory or other place)  Jul	y 23, 010	_		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other Specify Frederick Crematory 2 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Sta	.010	Fre	ederick	, Maryland
Ba Depart Imp	4	1621 Opossumtown Pi	uller r ke Fre	der	raı nome ick. Ma	es, P.A. rvland 2170:
Physician	7	23a Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or				Approximate Interval
/Medical	_	failUre List only one cause on each line  Immediate Cause (Final disease a. Hyperglycemic ketoacidosis				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	<u>                                     </u>	cause. Enter Underlying Cause				
ted Insit	<u> </u>	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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'60, sate be execu oblysician and ne burial - tra	ξL	AMENDED 23a, PII, 27, per ME g905 7/22/10 TT				
376 ificate ig phy s the l		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 24c. If yes, outcome of pregnancy 25c. If yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of yes, outcome of	nov		Date of delivery  Month	oay Year
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by the attending school of the death certification.	<u></u>	1 Yes 2 No 9 Unknown 9 Unknown				
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Records, I The law requires freate has been sig page 2 should be	5		perform 1 ✓ Yes 2		death? 1 ✓ Ye	s 2 No
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical examiner?	nly one)			
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Division of Vital Records, P.O. ral or attending Physician: The law requires that the staffer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detached by the funeral director.		1 X Notural (Month, Day, Year)	28d, Describe h	ow injury	y occurred	
Sior Aftend death cctor: by the	ξ	2 Accident Investigation				
Division ospital or Attending spital or Attending tours after death.  neral Director: After filled in by the fine Certification:		Suicide Could not be determined (Capacity)	28f. Location (Si or Town, St		Number or Ru	ral Route Number, City
ospits nours unera		4 Homicide (Sport)				
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitival Certification: To Be Completed by Physician Madical Ex	3	check only one)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at				
To with To com		29b. Signature and title of certifie 29c. License number 29c. License number		29d. Da	ate signed (Mor	ath, Day, Year)
		O.C.M.E.		June	18, 2010	
	-	30. Name and address of person who completed cause of death (Item 23a)				•••
5		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201			
State	e :	31. Date filed (Month Day, Year) 2010 32. Registrar's Signature				
Registra	Щ					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician June June 13<sup>ay</sup> 20ÎÎ Benjamin Carl Phebus 7:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6705 Sharpsburg Pike Washington Sharpsburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days 1 ★M 2 □ F Director 219-02-4358 27 Feb. 10, 1983 Maryland Usual Residence of Decedent show 10a, State 10b. County 10c, City. Town or Location 10d Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expriment must be notified at Director 1 ☐ Yes 2 🕱 No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 6705 Sharpsburg Pike 21782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married 1 ∐Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Garfield Phebus Joanne ပ္ Apple 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Phebus-Father 1009 Haws Drive Jonesborough, Tennessee 37659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If its any injury or o 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory June 15,2010 Hagerstown, Maryland 21. Signature of Funeral Service Osloomend Promer affilitione, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wellmont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the functed director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours a

> State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nothon ne Hagentown

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

29b. Signature and title

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 45PM ROSE THLEGN /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore None Mercy Hospita

5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/17/1947 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗙 F 63 Director 392-50-2077 Wisconsin Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show Department of Health and Mental Hygjene. Important: "or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examinar must be modified at applying or other traumatic event, the Medical Examinar must be modified at once. 1 ☐ Yes 2 ☑ No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5195 Britten Lane United States 21043 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2√ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Stoiber Clara Braunreiter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant; If item 27 is 1 John H. Ross - Husband 5195 Britten Lane Ellicott City, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 06/14/2010 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can see on each line. Immediate Cause (Final Physician Due to (or all a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Due to (or as a consequence of): Box 68760. or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ Ho P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩ ☐Inpatient 2☐ ER/Outpatient 3☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Division of Vital Records. within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

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State Registrar 29b. Signature and title of certifier

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

ST. PAUL

29c. License number

- BAIN MORE

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05/3172010 Physician/ Blanche E. Rankin 13:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 X Months Days Hours Min Director U772871920 578-26-4911 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XYes 2 ☐ No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 **AZU** Mike Shapiro Dr. Apt.114 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Dept. of Defense Bindery Worker Be filed 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed treent of Health and Mental H rtant: If item 27 is marked of jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Malachi Rowe Marion Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35th St. Apt. 5 NW, Washington D.C. 20007 <u>Paul L. Rankin / son</u> Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) incoln Cemetery 06/09/2010 Brentwood, MD 21. Signat re o Funeral Service 22. Name and Address of Facility Strickland Funeral Services <u>6500 Allentown Rd., Camp Springs, MD 20748</u> 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ☐ Live Birth 2 ☐ Fetal uea ☐ Pregnant at time of death in the past 12 months? Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopu, performed : certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide within 24 hours a Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit of ertifier 29c. License number

023

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year 2010 SARAH INEZ SMALLWOOD JUNE 539 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Davs Hours Min. 1 M 2 DXF Month Day Year) 12/31/1924 Director Yrs. Pleaseant Ln,SC 579-28-1706 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🏝 Yes 2 🗆 No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3040 Bexley Place # 903 20746 United Ststes 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced "natural", Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Interior Decorator Private Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Health and Ment tem 27 is marked other traumatic e Johnnie Ouzts Ollie Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Smallwood / Son 2762 Bruce Place SE Washington, DC 20010 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ott 14 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2010 Suitland, Maryland Washington National 21. Signature of Funeral Service L 22. Name and Address of FaciPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 1885 Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dueummia disease or condition Medical resulting in death) Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ 🚜 Other: Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pt 124 hours after death. e Funeral Director: After the leted filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical 🗝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) June 7, 2010 une c

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month,

JUN 1 1 2010

1001

Livingh Kool

dress of person who completed cause of death (Item 23a) (Type, Print) , ANNER M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4	partment of Health and Nertificate of Death		iene 2010	19867
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Ruby L. Stewart		2. Date of Death	1	3. Time of Death 12:40 Р м
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	<u> </u>	4c. County of Dear	
	<b>E</b> xamin		Prince George's Hospital Center	Cheverly		,	George's
	Funeral		5. Social Security Number  6. Sex 1	Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		577-46-4427 1 M 2 M F 80 Yrs  Usual Residence of Decedent		July 1,	1929   Sou	ith Carolina
	and show	or	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryla 8a-f : tified	Director	Maryland Prince George's	Cheverly			1 X Yes 2 ☐ No
	a or 2 be no	Ö	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	h with	Funeral	3116 Cheverly Avenue	20785		United St	ates
	r deat or iter iner		11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No	<ol><li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	safte ral", d Exam	ed by	3 Midowed 4 Divorced If Yes, Give Year or Dates.	1 🗌 Yes 2 🖰 No Specify:		Specify: B1	ack
5-0	hour natu	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of work	ina	16b. Kind of Business	Industry
2	hin 72 ne. <b>than</b> '	luo:	Elementary/Seconday (0-12) College (1-4 or 5+)	. DO NOT use retired)		C	
d 2	ed wit Hygie Sther	Be C	17. Father's Name (First, Middle, Last)	Housing Specialis		Governme	<u> </u>
au	be filk ental 'ked c	To	George Craft	io, Motilers Main	Mary Bi		
ary	hould and M s mai	, ,	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rura	al Route Number,	City or Town, State, Zij	o Code)
Σ	nd 2 s ealth a m 27 i			16 Cheverly Avenue	Cheverl	y, Md. 20	0785
ore	je 1a tof H If ite or oth		1 Durial 2 Cremation 3 Removal from State cemetery, of	rematory or other place)		20c. Location - City or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Lee's		/2010	Clinton,	
Ba	perm Depa Impo any i	, J	21. Site ture of Funeral Service Lice	22. Name and Address of Facility Ste 4001 Benning Road	wart Fur NE Wash	eral Home, ington, DO	Inc. 20019
			23a. Part the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			st,	Approximate Interval Between
	Inysician/ Medical	8 9	and the state of t	. kidney disec	72		Onset and Death
	Examiner		Due to (or as a consequence of):				
		iner	Sequentially list conditions, D.		٥.		
	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.	HEART Failur			
	e execian a	dical E	resulting in death) Last Due to (or as a consequence of):				
760	cate b physi s the b	edic	d				
89	certifi ending use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of de	livery
Box	death	sicis	1 Ves 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
o.	at the d by th etach	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I	230 Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 687	ires th	d by			1 ☐ Ye		robably 4 Unknown
ord	v requ	Completed			24a. Was an		topsy findings available
3ec	The lay	Com		<u> </u>	autops; perform 1 \(\sum \) Yes 2	ned? death?	completion of cause of
<u>e</u>	sian: T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		<u> </u>	
⋛	Physic this ce al dire	은	1 Yes 2 No 1 Inpatient 2 ER/Outpa	,		nce 6 Other (Spec	ify)
0 U	ding F h. After funer	Certificate:	27. Manner of Death  1 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injur		28d. Describe hov	w injury occurred	
Sio	Atten	rtiţi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Str	eet and Number or Ru	ral Route Number,
<u>≥</u>	tal or rs afte al Dire		building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	t the time, date and	I place, and due to the	cause(s) and manner stated.
	To the with To the company of the co		29b. Signature and title of certifier  Michigan Abdena, mo	29c. License number		Od. Date signed (Month	
7			30 Name and address of person who completed cause of death (Item 23a) (Type	e, Print)			
L	. Ch		MUCE.ml Andellu wo	3001 Hospital Dr	ive Che	verly, Md.	20785
	Stat Registra	ır	31. Date filed (Month, Day, Year)  JUN 1 2010  32. Register's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 June Althera Stiggers 5 3:52 A<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly 8. Date of Birth

(Month, Day Year)

Jan. 12, 1949 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Hours 61 Country) Missouri 348-38-7525 Director Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ant: If item 27; is marked of other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🕱 Yes 2 🗌 No Prince George's Capitol Heights Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 United States 1000 Cypress Tree Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Forman Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Ross Samuels Georgia Samuels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207472103 Addison Rd. South #2 District Heights, Md. Alexandra McClurkin/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place)
Park Lawn
Memorial Gardens 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 2010 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not en er the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ mojastatic disenso disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cuncer bregg+ Sequentially list conditions, Examine If any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 | Ilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Preymonia Records, 1 Yes 2 No 3 Probably 4 Hunknown Cacheria 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 this certificate has turom bosis performed Deep Venous 2 1 No 1 Tes Division of Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29c. License number 00043662

State Registrar PG Horpital

3001 Hospital Dr.

Cheverly, Md.

20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wy

32. Registra 's Signature

150416

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Lee Spaid Month 1545 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Communits Lanhan 6 eorge Hos Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Sex 1XX1XX2□F Date of Birth
Manyh200y/19948 g. Birthplace (State or Foreign **Funeral** 578-66-4065 Months Hours Min. 61 Washington, DC Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince Georges Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6509 Greenfield Ct. 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 You Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Bio-Chemist FDA Be 18. Mother's Name (First, Middle, Maiden Surname) Ruth Moreland Spaid 17. Father's Name (First, Middle, Last) and Mental I ည Giles H. Spaid other traumatic t. Page 1 and 2 should be treent of Health and Mertant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Dondldson (Sister) 13623 Diamond Head Dr. Tampa, Fl. 33624 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ö Chesapeake Crematory Department of Important: If any injury or once. 6/10/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licens 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the di or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Atheroset disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him recipitate cause. Enter Underlying Cause (Disease or iinjury Dun to for as a nonsequence on Examir ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year ed by the a detached f Unknown 9 🗌 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital 2 🗌 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1- Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Μ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, WS AMEND ITEM#9, II, 12, 15–18, 20a-c&22perff, 0903, 4/2, Legible, WS State of Maryland / Department of Health and Mental Hygiene U U AMEND ITEM#5perff, G905, 7/14/2010, WS Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17<sup>Pay</sup> Physician/ June 20TO 3:00 AM Carlyle Short Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) HD 6. Sex . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Davs Hours Min. Feb 23, 1931 Director 79 Usual Residence of Decedent show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 USA 107 University Boulevard 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?unk Black, White, etc. 1 Never Married 2 ☐ Married ģ 1 Yes If Yes, Give Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Construction Be 17. Father's Name (First, Middle, Last) - Unite 18. Mother's Name (First, Middle, Maiden Surname) Unk-မ Sophia Lyles Eddie Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wilburn - sister 5530 Wisconsin Avenue; Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from
4 Donation 3 Disposition (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ō 6/29/2010 La Plata, MD injury St. Matthews Church Briscoe-Tonic Funeral Home Siar Kona id any i Washington Rd. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No Completed 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perforn certificate Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury 28c Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No Director: After this funeral ( 27. Manner of Death 1 ☑ Natural 2 ☐ Accident Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🗆 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Carl Shifler June 10, 5:40 P M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 21 North Cleveland Avenue Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 82 Director 236-22-5828 Oct. 26,1927 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show ?7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Evansians on any the statistical Director 1 XYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 North Cleveland Avenue 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify. <u>გ</u> Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event. December 1. Elementary/Secondary (0-12) College (1-4or 5+) Manager Auto Parts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Clayton Shifler Ethel Katherine Lynch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally M. Shifler (Wife) 21 N. Cleveland Ave. Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park June 14,2010 Hagerstown, Maryland 22. Name and Address of Facility Osborne Funeral Home P.A. 42
Williamsport, Maryland 21795

anock, or heart failure. List only one cause on each line. 425 S. Conococheague St. Immediate Cause (Final **Physician** one disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical th, as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Month Year Day 5 ☐ Other (specify) ed by the detached o 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by signe be ( icate has been si 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy Hospital or Attending Physician; The certificate performe death? Division of Vital 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 24 hours after death. Funeral Director; A 2 Accident 1 ☐ Yes 2 ☐ No filled in by the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely Theck only within 2. 29b. Signature and title of certifier 29c. License number e and address of person who completed cause of death (Item 23a) (Type, Print) U.4 ASSIII

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 14

2010

32. Redistrar's Signature

IIIIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IURNER JUNE 4. 2010 SARAH 9:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8006 54th Ave. Prince George's College Park 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Hours Min Month, Day, Year) Director 90 218-24-6481 Curthage, NC Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 15 marked of other than "natural", or items 23a or 28a-f sho amyortant if item 27 15 marked of other than "natural", or items 23a or 28a-f sho amyortant in item 25 is marked of other than "natural", or items 25 or 28a-f sho amyor in into yor other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8006 54th Ave. 20740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 😾 Married Yes 2 No ģ Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. Black 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Supervisor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk ည Steven Worthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8006 54th Ave. College Park, Maryland 20740 Ronald Turner / Grand Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place.
Lincoln Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State June 14,2010 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1: Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the bunal-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Hospital or Attending Physician: The law requires Completed 1 🗆 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 55/eparthmin Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2X No 1 🗌 Yes ဂ္ဂ Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA s after death.

I Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) D17843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3311 Toledo Terrace + B102 tryaltsville And. 20182 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary S. Wilson 41 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Med. Ctr. Cumberland <u>Allegany</u> Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Hours (Month, Day, Year) une 24,1921 Ridgeville, **Director** 371-20-3681 88 June Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified. MD Allegany Rawlings 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15918 Bloomingfield Drive USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 2 🔀 No 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Food Preparation <u> County School System</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Reuben Sowers Virginia Katherine Delawder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard Wilson/ Son P.O. Box 173 Rawlings, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State June 16 4 ☐ Donation 5 ☐ Other (Specify) <u> Thrush-Hott Cemeterv</u> 2010 Burlington, WV 21. Signature of Funeral Service 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OGONARY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate if any, leading to immuce cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consecuents of Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : performed? Yes 2 No 25. Was case referred to medical completed filled in by the funeral director Be 26. Place of Death (Check only one) Hospital 2 1 Tyes 2 🗷 No Other: After this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury within 24 hours after death. **To the Funeral Director:** A ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 30. Name and address of person who completed ause of death (Item 23a (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Robustiano

31. Date filed (Month, Day,

Barrera,

M.D.

Registrar's Signature

KNEWA

Dr.

200 Glenn Street

Cumberland,

MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 28, 2. Date of Death 3. Time of Death Physician/ Naomi Watkins May 1:45 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Angel Gardens Group Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Mi 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 DC. **Funeral** 1 □ M 2 🖾 F Months <sup>(ear)</sup>1920 DC Director 90 Yrs 215-44-3868 Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Cheverly 1 X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 1704 61st Avenue United States death items Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: African "natural" 3 X Widowed 4 Divorced Completed Americar the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working alth and Mental Hygiene.
27 is marked other than "
r traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Effie Bell Patrick Tolliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 20905 14604 Antietam Court Silver Spring, Md. Charles B. Watkins, Jr./ Son Date 5, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State June Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 2010 Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dehydration Due to (or as a consequence of) as the burial-transit Advance Dementia and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day signed by the a g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? History of Breast Cancer 24a. Was an page 2 s has autopsy performed? Yes 2 No r: After this certifica e funeral director, p 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 🗷 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Group Home 27. Manner of Death 28c. Injury at work? 1 □ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) MD037511

Registrar
DHMH 17 Rev 7/2009

State

1160 Varnum Street # 021, NE Washington, DC

20017

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

Deepa Balasubramanian, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF, G905, 777/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Marvin Clarence Williams /Medical OL-O2-2010 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 11300 Trafalgar Court Prince Georges Ft. Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 □ F Days Months Director Vrs 579-46-7843 72 01/09/1938 NC Usual Residence of Dec Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Midical Examination at the notified at Ft. Washington 1XYes 2 □ No MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11300 Trafalgar Ct. 20744 Funeral AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) 75 Vehicle Operator U.S. Postal Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ George Lorenzo Williams Catherine Barnes 19a Informants Name/Relationship (Type. Print)
Phyllis J. Williams
Phyllis B. Williams / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11300 Trafalgar Ct., Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 Burial \_2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) Harmony Memorial Cem. 06/08/2010 Landover, MD 21. Signati, 22. Name and Address of Facility Strickland Funeral Services 23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 pe Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes Hospital or Attending Physician: filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 ☐ Other (Specify) s after death. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signal State JUN 1 0 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 49AM George Roland WOLFE, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min May 4 1945 Director 217-42-9417 65 Maryland Usual Residence of Decedent 28a-f sho 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits be notified 1X Yes 2 No Maryland Washington Hagerstown 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 119 Randolph Avenue 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force ō Black, White, etc. چ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 X Divorced Specify. Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 0 Brick Layer Masonry Be 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ၉ Noah Wolfe Mable Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Wolfe - Son 119 Randolph Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If its any injury or of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 6/16/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami and -transit resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown been signed by should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 2... Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 Froutpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the bases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Hedical Examiner: To the bases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

111

32. Rigistrar's Signature

## Phy /M Exa Fune Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any initing or

Baltimore, Maryland 21215-0036

Physici /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and compliably filled in by the financial director man 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

WH-16

State Registrar

12916 Conamar Dr 31. Date filed (Month, Day, Year) JUN 14 2010

		Please Type or Pr	int in Black II Maryland / Der			-	_			
	_	For State Registrar		ertificate of			g. No. 2 ()	0 19877		
sicia	n	1. Decedent's Name (First, Middle, Last)  Hazel Current	WATTERS			2. Date of Death Month June 11,	Day Yea	3. Time of Death		
edica mine		4a. Facility Name (If not institution, give street and number		4b. City, Town, o	r Location of Death	Julie 11,	4c. County of De			
		11850 Indian Lane 5. Social Security Number 6. Sex 7. A		Hagerst	OWN	8. Date of Birth	Washing	irthplace (State or Foreign		
rai tor		5. Social Security Number 6. Sex 1 ☐ M 2	Age (In yrs. last birthda 64 Yrs.	Months Days	Hours Min	June 30,	Year) (	Ssouri		
		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits		
	ctor	Maryland Washington	Hagersto	wn				1 □Yes 2≹ No		
	al Director	10e. Street and Number 11850 Indian Lane		10f. Zip Code	21742	10	g. Citizen of What (	Country?		
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ⅓ If Yes, Give Year or Dates	5? ] No	er in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes  No Specify:				lo- 14. Race - American Indian, Black, White, etc.  Specify: white		
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	r 5+) (Giv	cedent's Usual Occup ve kind of work done b. DO NOT use retire	ing	6b. Kind of Busines	s/Industry Education			
	Be Co	12 2  17. Father's Name (First, Middle, Last)		teacher	18. Mother's Name		aiden Surname)			
	ဥ	Unknown  19a. Informant's Name/Relationship (Type. Print)	19b. Ma	illing Address (Street	and Number or Run					
	Marcia Watters - daughter 11850 Indian Lane, Hagerstown, Maryland									
		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or 1   2 light Cremation   3   Removal from State   4   Donation   5   Other (Specify)   Hagerstown Crematory   2010   Hagerstown								
once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  415 East Wilson Blvd., Hagerstown, Mar								
an		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CEREBROVASCULAR ACCIDENT STROKE								
er		Due to (or a	as a consequence of):	N				YEARS		
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	ш	that initiated events c.	as a consequence of):							
	edica	d								
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   23d. Date of d   Month								
	d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to 1 X es 2 No 3 Pr								
	Completed	CHRONIC OBSTRUCTIVE	24a. Was an	24a. Was an 24b. Were autopsy fin autopsy prior to completic						
		Hyperlipidemia				perform 1 □Yes 2	ed? death No 1 □ Y			
	o Be	25. Was case referred to medical examiner?  1   Yes 2   XiNo								
5	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	njury Day, Year) 28b. Time Injury	y Wor	of 28c. Injury at Work? 28d. Descri			, ,,		
	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	njury - At home, farm, etc. (Specify)				Location (Street and Number or Rural Route Number, City or Town, State)			
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besidence and manner	of examination and/or							
	Me	29b. Signature and title of certifier	27	29c. Licens	se number	,	d. Date signed (Mo			
		30. Name and address of person who completed cause o	f death (Item 23a) (Typ				2.2			

21742

MD

Suite 201 32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Norman Anderson : 00 P :M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1909 Deer Spring Court Harford Forest Hill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours (Month, Day, Year) 81 1928 Maryland Director 218-22-3100 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Forest Hill 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 1909 Deer Spring Court 21050 United States items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 K Yes 2 No
If Yes, Give
Year or Dates. ò Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify White traumatic event, the Medica 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Manager permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Gustave Anderson Myrte E. Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Anderson /Wife 1909 Deer Spring Court Forest Hill, MD 21050 20a. Method of Disposition Date Jun 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Beltsville, Maryland Chesapeake Crematory 2010 Signature of Funeral Service Licen 22. Nam@menAatesonFasifid Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ENd-Stage LOPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 2 🔽 N ☐ Yes 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 100 Other: ဂ္ဂ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MSRAJUPAKISEMI C

.s. Kujupakemp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. RW WALL MP 7535 S WIM TV

32. Registrar's Signature

DHMH 17 Rev 7/2009

**ORIGINAL** 

29c. License number 005 7465

5-235, Baltomore, 2120 en

6/24/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00 mona Medical 4a. Facility Name (if not institution, give street and ity, Town, or Location of Death Examiner nty of Death woods ambrio ocial Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral Dec 28 219-12-7739 1 □ M 2 □**X**F Hours Maryland 85 Director Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Funeral 21613 525 Glen Burn Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Surname)
Maude Batchelor မ William G. Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
110 Holly Terrace Cambridge, MD 21613 110 Holly Terrace Donna Gipe (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State 1 ☐ Burlal 2 XCremation 3 ☐ Removal from State 6/23/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee <sup>22.</sup>Name and Address of Facility Gary L. Kaufman Funeral HOme at MMP 7250 Washington Blvd., Elkridge, MD Inc. 21075 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause or each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Demento Physician/ disease or condition resulting in death) dronce Medical Due to (or as a consequence of) Cordio volcula diter Examiner teriosclander Sequentiary liet conclitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ne 24a. Was an has autopsy Director: After this certificate Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 1 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural injury 5 Pending □ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYRN CAMBRIDGE MD 216/3 10MAN State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06/21/2010 Рм 3:05 Gisela Conti Botts Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City Morningside House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 K F Months Days Hours Min. Director Yrs 0277771928 Germany 82 <u>480-38-2</u>728 Usual Residence of Decedent show 10a. State at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 ☐ No VA Arlington Arlington ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral United States 3106 N. John Marshall Dr. 22207 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 □ Divorced Specify: Completed White Year or Dates er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic even is marked o မ Elfriede Louise Meerscheidt-Hullessem Leonardo Giorgio Conti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey G. F. Nugent- Son 10302 Bassett Hall Ct. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/22/2010 4 X Donation 5 ☐ Other (Specify) Uniformed Services Bethesda, MD . Signature of yneral Service Licenses 933 Gist Ave. 20910 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year detached 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24a. Was an 24b. Were autopsy findings available After this certificate has funeral director, page 2 autopsy prior to completion of cause of performed? death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 X No Other: 은 1 Inpatient 2 I ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTANT LIVE Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

e Funeral Director: After detection of the further fur 2 Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 125 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30 < DHI

DHMH 17 Rev 7/2009

State

Registrar

Ramesh Sabapathi 201-109 Back River Neck Rd. Essex MD 21221

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HIN 2.5 2010

D30641

06/23/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Alice Hancock Boyd JNE C 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES MD HOSPITA 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 👽 F Hours 220-18-7046 Director 84 April 11,1926 Maryland Usual Residence of Decedent within 72 hours after death with the Marvland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the martical Examinar must be natified at Baltimore Catonsville 1 □Yes 2XXVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane RGT110 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X**No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Secretary permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Item 2008. Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Hancock Sara Eleanora Foreman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Boyd Jr (Son) 632 Cove Terrace Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6/23/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enty the disease, or complications the raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cluse (Fine) 22. Name and Address of Facility Elkridge, MD Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) Prevnonia **Physician** wrnin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unierlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Pregnant at time of death the detached 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 **Y** No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be exec Box 68760 P.0. Division of Vital Records, e Funeral within 2 To the

Baltimore, Maryland 21215-0036

1

State

DHMH 17 Rev 1/200

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D47353

AVENUE

29d. Date signed (Month, Day, Year)

Bultmore, Maryland

P.O. Box 68760, Division of Vital Records,

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

(Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 22 <sup>™</sup>7010 3:50 A M VICTORIA FRANCES ZEMAK BANKNELL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE CITY KESWICK MULTI-CARE CENTER Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Hours APR 5 94 **Director** 041-05-1452 ONNECTICUT Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE CITY 1 X Yes 2 □ No N/A MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21211 USA 700 West 40th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PLASTIC MANUFACTURE Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ LESCHINSKY ZEMACK FRANCES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code (SON) 203 OVERBROOK ROAD, BALTIMORE, MARYLAND 21212 CHARLES BANKNELL, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREEN MOUNT CREMATORY 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 6/24/2010 BALTIMORE, MARYLAND 4 Doperion 5 Other (Specify) 21. Signatur of Fune a Service Line CAEACH NIEDEFELD FUNERAL U York Road, Baltimore, HOME, IN INC MARTIN D. LAWSON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emenTA Physician/ END STAG disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b Il director, page 2 sh autopsy perform death?
1 Yes 2 No Hospital or Attending Physician: The Be **Division of Vital** Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral directions. Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don m. n 901 north

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 252010

500

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10-04510	
Michael Blake	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chael Blake	State of Maryland / Department of Health and Mental Hy 1-For State  Certificate of Death		2010	19004
Physician	Registrar  1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death		3. Time of Death
্বical Examine	THE VALLE	June 14, 20		1642 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4115 Saint Georges Avenue  Baltimore		4c. County of Death	
Funeral	5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Birth	place (State or
Director	215-56-535/ 1 M 2 F 56 Yrs. Months Days Hours Min.	Jun 12	1952 Foreign	Rypud
any	Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
A .,	MD N/A BALTIMENT			1 Yes 2 No
the Maryland a or 28a-f show tifled at once.	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Count	ry?
th the M 23a or 2 notified	41/5 ST, (SPIRGES AVE APT, 2 212/18		U15,A	
r death with  or items 23 must be no	11. Marital Sfatus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of H		14. Race - Americ White, etc.	an Indian, Black,
frer de	3 Widowed 4 Divorced If Yes 2 No No No specify: or Dates:		Specify: BLA	K
"natural" Examine	15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation (Give kind of viging most of working life. DO NOT use retired.)		6b. Kind of Business/In	dustry
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exar	Elementary/Secondary (0-12)  College (1-4 or 5+)  Gos Can / Nas D4 T6 CN		Gr. Har/ 9	1675m
5-00% illed within Hygiene to the He Med	17. Father's Name (First, Middle, Last)	e (First, Middle, Ma	den Surname)	7.24.
P be fi	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or J	y LiW	AI 15_ State	Zin Codo)
and 2 should and 2 should lealth and Me tem 27 is ma traumatic ev	19a, Informant's Name/Relationship (Type, Print)  19b, Mailing Address (Street and Number of HTD)  19b, Mailing Address (Street and Number of HTD)  19b, Mailing Address (Street and Number of HTD)	- ALTE B	ALT, MAD. 1	11212
re, MC s 1 and 2 si ff Health at If item 27 ier traums	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	Oc. Location - City or T	own, State
MOF Pages nent of ant: If or othe	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify	24-10	Atorisva/18	11/9.
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other the	21. Signat of Fun all Servic Loense 22. Name and Address of Facility	70 MARIN	127018	21219
Physician	23 ax1. In the iseas, or complications that caused the death. Do not enter the node of dying, such as cardiac of	or respiratory arrest	, shock, or heart	Approximate Interval
/Medical	finder List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):			
يّ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ed nsit <b>Fxam</b> iner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			(T
and transit	d			
e ex	UNPENDED AMENDED			
68760 certificate b nding physics as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   1 Live birth   2 Fetal death   3 Fetal dea	ancy	23d Date of delivery Month D	ay Year
Box 6876 c death certificate the attending phy ed for use as the thy eight	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
D. Be trhe de by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
F.O. signed by the detact	Diabetes mellitus	1 Yes		ably 4 🗸 Unknown
w requ		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
		perform 1 Yes 2		s 2 No
ician:	25. Was case referred to medical examiner?  Hospital:   Input   Properties		esidence 6 🗸 Other:	Scene
of Vil ing Physic After this inneral dir	27. Manner of Death  (Month, Day, Year)  28. Date of Injury (Month, Day, Year)	28d Describe ho		
_ = ₫ ∵ ₹   7	1 V Natural 5 Pending 2 Accident Investigation			
Division o spital or Attending tours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rui te)	al Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	29a Certifier 4 Continue To the heat of my knowledge death accurred at the time date and place are	d due to the cause(	s) and manner as state	ed.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date ar	nd place, and due to the	e cause(s)
L S L O	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	oth, Day, Year)
	O.C.M.E.		June 18, 2010	,
	30. Name and address of person who completed cause of death (flem 23a)	1201		
Stat	31. Date filed (Month, Day, Year) 32 Register's Signature			

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2010 Physician/ Mary Merrick Bliss June 16, 10:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Nov. **Funeral** 8. Date of Birth 1 🗆 M 2 🕱 F Hours Days <sup>ar)</sup>1922 Director New York 87 <u>103-</u>12-0931 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No Harford Bel Air Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21014 128 W. Ring Factory Road, Apt. 140 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 ☐ No If Yes, Give Completed by 1 Never Married 2 Married 4 | 14 | 10 | 10 | 5 のハ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine (mnm) Walker Albert W. Merrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9893 Century Drive, Ellicott City, Maryland 21042 Katherine Bliss / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Hilltop Service Corp 06-19-10 21. Son the of Fury al Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Atherosclerotic Cordovascular Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sacuaritistic flet conditions Examiner if any, leading to immediate cause. Enter Underlying Varued Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Bliss Maly Mernal (1) 1000640 Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To I 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. **Certifying Nurse Practioner:** To the ends one late? Lent te Senurges and place 29b. Signature and title of cetifier Mos of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

JUN 25 2010

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32. Regis rar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 2010 8:15 P M MARY R. BILZER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5833 BELAIR RD N/A BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Hours 1 □ M 2√□ F Months Days 96 174-03-8323 Director MARCH 3,1914 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the the fical Exp. (in a count) 1 TYes 2 □ No Director MD BALTIMORE N/A 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? death with 5833 BELAIR RD 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No ≥ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY ELECTRONICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be B. RAY YOHE CARRIE A. HARMON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau BALTIMORE, MD 21206 5833 BELAIR RD MARY J. BILZER-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 6/26/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD ort 1. Ehter the diseas lications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, ne cause on each link. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 MNo
9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð cate has been signated by page 2 should b 1. Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2, No 24a Was an autopsy performed? 1 □ Yes 2 XNo certificate Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ funeral 28b. Time of Injury Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 25 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b.c.perFH.G904.6/25/2010.WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Year</sup>01( June 24, 1:10 AM Donald Francis Chaney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. Country yland 61 (Morth Bay, Year) 214-50-1704 1949 Director Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits with the Maryland ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director Baltimore 1 Yes 2 No Arundo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 Annabel Avenue 21225 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important. If item 27 is marked other than "natural", or items any injury or other traumatic events. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dry Wall Finisher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Chaney Anna Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Chaney /Wife 508 Annabel Avenue Brooklyn, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date Jun 25 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses MO1585 22. Name and Address of Facility Cremation and Funeral Alternatives Har 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between n et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached f 1 Yes 2 L 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 No 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 L**X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence eral Director: After this filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b ature and title of certification who completed use of death (Item/23a) (Type, Print) and address of per N. CHARLES ST WO 6701 32. Registrar Signatu

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 4:05 a M Ruth H. Collins 1 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1703 Pot Spring Rd. Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day ) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F Days Year) 19<u>19</u> Hours Mary Land 219-36-2152 90 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1703 Pot Spring Rd. 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Dept. Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Holland Pearl Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Pot Spring Rd. Timonium, Md. 21093 Ms. Donna Pate-Stumpfel/ Dtr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Fork U.M. Church Cem. 6-28-10 Fork, Md. 22. Name and Address of Familia Funeral Home, 21. Signature of Fun Service Lice 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Failure disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) ascular Secure dially list our fitting if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law equires that the death certificate be executed attending physician and for use as the burial-transi Atrial Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical tension ears Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown een si page 2 s in 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy his certificate hil director, page performed' 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific D66610 6-24-2010 M'D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

State

MARIE

MD

32. Registrar's Signature

SURENDRA

31. Date filed (Month, Day, Year)

JUN 2 5 2010

6565 N. Charler St. #203

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 2<u>010</u> Physician/ Month David Mitchell Crigger June 22 10:25P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18912 Rocky Road Sharpsburg Washington Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral 7. Age (In vrs. last birthday) Days Hours 1 DXM 2 DF Director 216-40-5705 69 1941 March 20 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Sharpsburg 1 Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18912 Rocky Road 21782 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Specify: White Year or Dates 1966-68 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Μ. Crigger Carmel Katy Mae Hensley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Crigger/wife 18912 Rocky Road Sharpsburg, Maryland 21782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Final Journey Crematory 6/25/2010 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD uanta M00957 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ Metay disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Due to or as a conse vience of cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner's Hospital Other: ျှ 1 🗌 Yes 2 🗓 1/0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, Year) State 5 Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signatur

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

750 Mainst Reisterstein, MD Ell36

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHELLIN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Frederick Cosgrove June 2010 6:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yea 1 XM 2 □ F Days Hours Director 173-24-5726 79 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7939 St. Claire Lane 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years AT&T Laborer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Charles Cosgrove Madeline Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 943 Stewartstown Road, New Freedom, PA. 17349 Mary V. Trovato Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 27, 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery Baltimore, Maryland 2010 21. Signature of Funeral Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of: Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending about the attending about the standard of the standard and the s IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🕱 No ျ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Tes 2 No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 To Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Mpnth, Day, Year) 2010

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State

Registrar

JACKIE JONES,

JUN 25 2010

31. Date filed (Month, Day, Year)

01:9

CONE

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

ress of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5:57 Medical institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harbor altimore -lospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) Months 1 🗆 M 2 Yrs. Director Usual Residence of Decedent or 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 ☐ No timore mb 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21200 cham 2. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ₩Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usaretired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Mide 19a Informant's Name/Relationship (Type, Print) State, Zip Code) nthia Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory another Date -20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Re noval from State 30-2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral/Service Licensee neene Funeral Services 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Prosician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Santa Lime of death Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical To the Hospital or Attending Physician: completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 1 Tes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work? 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hyun Don 3001

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE. <sup>Day</sup> 2010 LARRY ALAN CROSS 7:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford 109 Arbutus Drive Joppatowne If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) New Hampshire 8. Date of Birth (Month, Day, Jan. 6, 7. Age (In vrs. last birthday) **Funeral** Days Min 1 X M 2 □ F 1954 Director 003-42-7090 56 Jan. Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔼 No Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Arbutus Drive 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ced other than " event, the Mec Elementary/Seconday (0-12) 12 College (1-4 or 5+) Vice President Lumber Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental h should be fill and Mental ပ္ of Health and Ment fitem 27 is marked rother traumatic e David Hurley Cross Alice Marie Haggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2: Catherine Cross / Wife 109 Arbutus Drive, Joppatowne, Maryland, 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/2010 Darlington, Maryland Darlington Cemetery 21. Signal re of Fugeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. m <u>1317 Cokesbury Road, Abingdon, Maryland 21009</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Carcinoma 18 Mon Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? death? Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2X No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ▼ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Clearly redalthu D15546 June 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Padgett, M.D. 5601 Loch Raven Blvd., Baltimore, MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**ORIGINAL** 

State

Registrar DHMH 17 Rev 7/2009 JUN 25 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		1. Decedent's Name (First, Middle, Last)  2. Date of Death								3. Time of Death		
	Physicia Medic						June			20, 2010 3:00 P M		
	Examin		4a. Facility Name (if not institution, give street and number)			4b. Cit		Location of Death	ו	40	County of Deat	
	Function		12509 St. James Road  5. Social Security Number   6. Sex   7. A	ge (In yrs. last	hirthday)	If Lind	Roer 1 Year	ckville If Under 24 Hrs.	8. Date of Birt	Montgomery  9. Birthplace (State or Foreign		
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	ld now at	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	eation						10d. Inside City Limits
	larylar 3a-fsl ified	ecto	MD Montgomery		ckvi							1 ☐ Yes 2XXNo
	the M	ä	10e. Street and Number	1 100	JCRVI.		ip Code			10g. C	itizen of What Co	untry?
	n with	<b>Funeral Director</b>	12509 St. James Road		_		20850				USA	
	r death r item iner n		11. Marital Status 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Armed Forces 2 Married 12. Was Decedent Armed Forces 1 Never Married 12. Was Decedent Armed Forces 1 Never Married 13. Was Decedent Armed Forces 1 Never Married 14. Was Decedent Armed Forces 1 Never Married 15. Was Decedent Armed 15. Was Decedent Ar	Ever in U.S.	13. V	Vas Dece Yes, sp	edent of His ecify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Ame	
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5-0	2 hour "natu dical	plete	15. Decedent's Education (Specify only highest grade completed)	1	6a. Deced	ent's Us	ual Occupat	tion uring most of wor	king	16b. l	Kind of Business	Industry
121	thin 73	No.	Elementary/Seconday (0-12) College (1-4 or	5+)	life. DO	O NOT u	se retired)		in ig			
d 2	Hygie Other ent, tl	Be (	17. Father's Name (First, Middle, Last)		Sup	port	Serv		ne (First, Middle,		D A Surname)	
/an	d be fil fental rrked tic ev	မ	Oscar Wev						n Dixon		Carriarroy	
lan	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Addre	ss (Street ar	nd Number or Ru	ral Route Numbe	r, City o	r Town, State, Zip	Code)
	and 2 Health sm 27 ther tr		Frank Cowatch/ Husband					s Road			Maryland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	came	e of Dispo: etery, crem <b>gomer</b>	atoni or	other place	i	Date		ocation - City or	
altir	mit. Partme sartme sortan r injur.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Crem	gomer atori	.um, Name a	Inc.	06 / 2.	3/2010	Bet	hesda, M	larvland
m	permir Depar Impor any ir	(i )	> Flarge 41. (hacker	M01530	0 75	57 V	A. Pum Viscon	phrey fune sin Ave	eral Home/. nue Beth	Beth	esda-Chevy a, Maryl	Chase, Inc. and 20814
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4	Physician/ Medical		manufation to depute	dder Ca		oma						Onset and Death Months
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	ocuted and transit	Examiner	that initiated events C.	a consequenc								
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	cal E	resulting in death) Last Due to (or as	a consequent	ce oi).							
3760	ficate g phys	Medical	d									
89 x	aath certific attending   I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcom 1 ☐ Live Birth			Ectopic	pregnancy			-	23d. Date of del	ivery
Box	e death the ath hed fo	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of deat		Other (					Month	Day Year
P.O.	hat the ed by detacl	y Ph	Part II. Other significant conditions contributing to death	but not resultir	ng in the u	nderlying	cause give	n in Part I.	23e. Did to	bacco	use contribute to	the cause of death?
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of V	Phys r this ( ral dir	2	1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpa  27. Manner of Death 28a. Date of in	tient 2 ER/ ury 28t	Outpatien	1 🗆 🗈	28c. Injury	4 ☐ Nursing H	ome 5 K Resid		6 Other (Speci	fy)
ouc	Attending Phy or death. octor: After this by the funeral d	icate	1 ☒ Natural 5 ☐ Pending (Month, D 2 ☐ Accident Investigation	ay, Year)	injury	М	work?	es 2 🗆 No	ZOG. DOSCIDE II	Ow nijui	y occurred	
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e	jury - At home, tc. (Specify)	, farm, stre	et, facto	ry, office		28f. Location (S City or Tow			al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	~	29b. Signature and title of certifier		Ų-, u		c. License r				ate signed (Month	•
			· Cim 'fules	~		1	4D 328	364		6/	21/2010	
			30. Name and address of person who completed cause of				707	Wachda-	tom D (	, 0	0027	
	Stat	e	Ari Fishman, M.D. 2141 K. 31. Date filed (Month, Day, Year) 32. Regist	street rark Signature	NW S	ult	2 / U /	wasning	ton, D.C	. Z	003/	
	Registra		JUN 252010 angus	8. Ma	ale							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ 1:30 AM ESTHER RUTH COHEN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALtimore BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** 1 □ M 2 🕱 F Hours 1672771917 92 MDDirector 212-03-8083 Usual Residence of Decedent permit. Page 1 and 2 should be then wrum, remeasurer of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21209 7203 ROCKLAND HILLS DRIVE, #508 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married þ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tren & GOLDSTEIN MARY ZIMMERMAN HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 HAMLET DRIVE, OWINGS MILLS, MD 21117 EILEEN COHEN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD BETH TFILOH CEMETERY 6/23/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mats 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Le 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death myocordul inferction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner atherescleiche Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown P.O. I signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown Records, cate has been si page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital జ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Dending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ideala Bay, 4) 6/21/10 D0020604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Richard A. Berg, AD; Switc450; 10755 Fills Rd., Lullerville, Hd 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month une : 44 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death and N/A If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-14-1714 1 □ M 2 🕶 F Months Days Hours Min. Mary land Director Usual Residence of Decedent if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore Parkville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 21234 U.S.A. 8800 Walther Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 🙀 No Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Banking Elementary/Seconday (0-12) College (1-4 or 5+) Teller Be should be filed 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Hilda (Not Known) Frank Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 s ment of Health a ant: If item 27 i 5030 Morning Star Drive Dayton, Maryland 21036 George L. Doetsch, Jr. / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of I
Important: If it
any injury or o M Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2010 Dulaney Valley Mem. Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical death-ertificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law certificate has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mar ner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗆 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 8

State

Registrar

Amy lortone

31. Date filed (Month, Day, Year)

JUN 2 5 2010

0120 i

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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F	hysicia	an/	1. Decedent's Name (First, Midd	lle,Last)						2	2. Date of Dea	th		3. Time of Death
	Exami		James Eugene	e Donald	lson						June 18, 2	Day Yo 2010	ear	0702 hrs
1			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death					Death		4c. County		h		
			Upper Chesapeake N				Bel Air					Harford		
	uneral irector		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Bir	th(MM/DD/YYY	Forei	rthplace (State or gn
U	irector		293-50-4327	1 X M 2 F	<u> </u>	57 Yrs.		,-			June	29 <b>,</b> 195	2 0	ountry) Ohio
	ž.		Usual Residence of Decedent  10a. State  10b. County		10c City	, Town or Location	n							10d. Inside City Limits
_	8 AA													1 X Yes 2 No
Jana	a-f sh	tor	Ohio Gree  10e. Street and Number	ene	F a	irborn	10f. Zip C	ode			11	0g. Citizen of V	Vhat Cou	
Ma	or 28 Ted a	Director	12 Galewood	Drivo							T.			and y :
4	or items 23a or 28a-f show any must be notified at once.		12 Galewood		ecedent Ever in U	IS 13 Was		324	anic Origin	2 ( Sne	cify Yes or No	U.S.A		rican Indian, Black,
445	items ist be	uneral		larried Armed	Forces?		s, specify						ite, etc.	ricari ingian, biack,
4	", or	т	3 X Widowed 4 Di	1 X Yes vorced If Yes, Give Y	2 No	1	Yes 2	( No	specify:		Specify: Wh			ite
2	ntura	d by	15. Decedent's Education (Spe	or Dates: ecify only highest gr	ade completed)	16a. Decedent	's Usual O	ccupatio	n (Give kir			16b. Kind of E		
3 01	n "n	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during mo	st of worki	ng life. D	OO NOT us	se retire	d)			
03	ene. r tha	m			1	Truck	Dri	ver	?			Truck	ing	Company
5-0-2	Hygi 1 other		17. Father's Name (First, Middle									Maiden Surnam	ne)	
21215-0036	ental arke	Be	Estle E. Don			404 11 11					J. G			
MD 2	and M 7 is m	5			/- :							nber, City or To		
<b>Σ</b> γ	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Stephanie Do	nalason	<u>1/Daugn</u> 120b.	Place of Disposit	<u>llnn∈</u> ion (Name	of ceme	<u>1111</u> eterv.	Ro	ad, Ch: <sub>Date</sub>	20c. Location	the 1 - City o	<u>, ON104560°</u> r Town, State
Baltimore,			1 Burial 2 X Cremation		from State	crematory or oth	er place)						,	
tim.			4 Donation 5 Other S		Ar	dentCre	emati	on,	In¢	<u>. 6-</u>	21-10	Hanov	er,	Maryland
Bal	Injur		0 1 1 1 0	11		22. Na	ame and A	aaress c	T Facility	Mar	zullo	Funer	al	Chapel, P. A
	/sician		23a. Part I. Enter the disease, o	remplications that	caused the death	160( n. Do not enter th	9Har	<u>ctor</u> dvina, si	cd Rouch as car	oad diac or i	Balt:	imore, est, shock, or h	Mar leart	y Land 21214 Approximate Interval
	edical		failure. List only one cause	on each line.	erotic Cardio			, ,						Between Onset and Death
Exa	miner		Immediate Cause (Final disease or condition resulting in death)	_	a consequence		ase							
			Sequentially list conditions,	b										
		ner	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):								
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hatted	nd transi		<b>3</b>	d					_					
Division of Vital Records, P.O. Box 68760,	ysician and burial - transit	dical	UNPENDED	AMENDED	)									
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.89 	the attending phy	Physician/M	23b. Was decedent pregnant in t past 12 months?	I I LIVE	birth gnant at time of d	oath	al death	3	Ectopic p	oregnan	су	Month		Day Year
Sox	the atter	ysic	1 Yes 2 No 9 Ur	known	nown	eath 5 Oth	er (Specif	y)				1		
O. E.	by th		Part II. Other significant condi	tions contributing	to death but not	resulting in the ur	nderlying c	ause giv	en in Part	1.	23e. Did to	obacco use con	tribute to	the cause of death?
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	certificate ector, page		25. Was case referred to medical	al I			26	Place o	of Death (C	heck or		2 V No	1 Y	es 2 No
/ita	his certificate l director, page	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		10	thor:		Home 5	Residence 6	Othe	er:
of .	After th	-	27. Manner of Death	28a. Dat	te of Injury	28b. Time of In		c. Injury	at Work?			how injury occu		
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/isi	ofter death Director: in by the	Certification:		stigation 28e. Pla	ace of Injury - At h	nome, farm, stree	t, factory, c	office bui	ilding, etc.	2			ber or R	tural Route Number, City
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Hoen	within 24 hours after death  To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying F	hysician: To the b	est of my knowled	ige, death occurr	ed at the ti	me, date	e and place	e, and d	ue to the caus	se(s) and mann	er as sta	ited.
, the	within 24 h To the Fun completely	Medical		aminer: On the basis and manner		and/or investigati	on, in my o	pinion, o	death occu	urred at	the time, date	and place, and	due to t	he cause(s)
	5 H c	Me	29b. Signature and title of certification					License						onth, Day, Year)
				4MM	le			O.C.M	l.E.			June 19,	2010	
			30. Name and address of perso		,	,						-		
				puty Chief Med					more, M	ID 212	201			
	St	tate	31. Date filed (Month, Day Year	5 2010 32.1	Registrar's Signat	ure /	es de	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22<sup>Day</sup> June Physician/ 2010 Elsie 8:50 P M G. Douglas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Hospice of the Chesapeake Linthicum Heights Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 8 / 11 1 □ M 2 🗓 F Hours Mary land Director 214-26-5950 Yrs 1929 80 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6502 Home Water Ct. #201 21060 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 K Widowed 4 □ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Carson Eugene Golladay Lucy Florence Strickler 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Carolyn Golladay Rain Water Way #202; Department of Healt Important: If item 2 any injury or other once. Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville MD Vet. Cem 6/28/2010|Crownsville, Maryland 21. Sign gu'e of Juneral Servin Lt. nsee 2. Name and Address of Facility irkley-Ruddick Funeral Home, P. 21 Crain Hwy. SE; Glen Burnie, 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMALL CELL LING CANCER Physician/ METASTATIC disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himnediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 X No 1 Yes 2 No **Director:** After this certificd in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) Hopsice 1 Yes 2 💢 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident within 24 hours after dea To the Funeral Director completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifie 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, occan become at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatura and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

405 Frederick Fr.

32. Registrar's Signature

Ensur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott Poulton, M.D.

31. Date filed (Month, Day, Year)

6100400

Ste. 204;

arks

June 23, 2010

21228

Catonsville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 1:20 A-M /Medical 4a. Facility Name (If not institution, give Examiner e of Birth Say, Year)

9. Birthplace (State of Country)

9. 30,1950Maryland 5. Social Security Number (In yrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 59 214-56-4451 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be motified at 1 ☐ Yes 2 No Director Baltimore Gwynn Oak Marylan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5404 Gwynndale Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes Mo Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Social Worker/Supervisor Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geraldine Dorothea Hazelton Samuel William Mackall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5404 Gwynndale Ave Gwynn Oak, Maryland Paul Edwards/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Maryland Woodlawn Cemetery 4□Donation 5夕Other (Specify)Entombment 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funery Service License \$240 Reisterstown Rd Baltimore, MD 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyng Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Onknown o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ has been si e 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performer page 2 □ No 1 ☐ Yes of Vital 2 🗷 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examina? 1 ☐ 1es 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manna Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 0

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

**ORIGINAL** 

ddress of person who completed cause of death (Item 23a) (Type, Print) tansen M.D 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G904, 6/30/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Mary Lou Emerson 0610 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12033 Bunkhouse Road Lusby Calvert If Under 24 Hrs. 5. Social Security Number 2 8. Date of Birth (Month, Day, Year) May31, 1928 9. Birthplace (State or Foreign Country)District of Columbia 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2**X** F 82 of **Director** 218-24-<del>2874</del> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov tre Posical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 621 Middlesex Road 21221 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🙀 No Specify: 2 Specify: White 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item Z7 is marked other any Injury or other traumath. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sherman C. Twigg Cora Worsham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12033Bunkhouse Road, Lusby, Maryland 20657 Michael Emerson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, INC. 6-23-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 6009Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Monic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Mo O. been signed by the should be detached 9 Unknown 9. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed The certificate 1 □Yes 2 □No of Vital Hospital or Attending Physician: this certificate al director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours af the Funeral Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 238 MICON 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOMINION DOMINION If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. (Month, Day, Year) MAR- JLAND Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No DMINION 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WhIT to 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MO-21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State -23-10 4 Dongtion 5 Other (Specify) DDENTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if at y, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Que to (or as a consequence of, attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) been signed by the s should be detached g Unknown g 🗌 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Drath 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yeş 2 🗌 No 2/☐ Accident 3 ☐ Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

32. Registrir's Sign

DAPPINI LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 517 Month am Marie Elizabeth Geter une Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death GreneRal Maryland saltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Hours Min. Director 20-24-9893 MD Usual Residence of Decedent Silvers are Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov is marked other than "natural", or items 23a or 28a-f shov is marked other than "natural", or items 23a or 28a-f show is marked of the second of the seco 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director X□ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Eutaw Place Apt 1012 21217 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maye Geter Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Supervisor Department Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Pride Sr. Ruby Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Carolyn</u> Lundy-Daughter 8526 Brest Road, Randallstown, Md 21133 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Baltimore National 7/1/2010 Baltimore, Md of Funeral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign Baltimore, Md 21215 23a. Part . Enter the sease, or complications that calls shoot, or hear tailure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner and Due to (or as a consequence of) resulting in death) Last attending physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ■ No 3 □ Probably 4 □ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 N 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending Accident
Suicide Investigation Could not be 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4  $\square$  Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

JUN 25 2010

of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sigr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CONCETTA RITA BATTAGLIA GEPPI 4:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER Towson BALTIMORE COUNTY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth
(Month Day, 1 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min MARYLAND 214-72-5683 Director 102 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or bother traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🎗 No MARYLAND BALTIMORE COUNTY BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 HOPKINS ROAD 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ SALVATORE BATTAGLIA Santa SERIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rose P. Fischer (Daughter) 405 HOPKINS ROAD, BALTIMORE, MARYLAND 21212 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of Cermetery, crematory or other place)

Dulaney Valley M. Grdns 6/25/2010 Timonium, Maryland 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat F F Several See MITCHELL WPEDEFELD FUNERAL 6500 York Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ance 5+ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 WNo Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case réferred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural injury 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certif License number 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

WOU

MEUSSA 3 31. Date filed (Month, Day, Year) N. CHARLES ST. BALTIMORE, MD

	o .	NDED BY COURT ORDER Please Type or Print in Black Indelible Ink. Ensure All C	opies Are L	egible.	
Alphonso Gaye		State of Maryland / Department of Health and Ment  1- For State Registrar  Certificate of Death	al Hygiene	Reg. No. 201	0 19904
Physic Medical Exam			2. Date of De Month	Day Year	3. Time of Death 1811 hrs
incultur Exam		Alphonso B. Gaye, Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of	May 30, f Death	4c. County of D	
		University Hospital Baltimore			
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 230–23–5086 1 X M 2 F 47 Yrs. Months Days Hours	Min	9. /1962	Birthplace (State or oreign Country) Liberia
ınd show any	5	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show any sis be notified at once.	Director	10e. Straggard Number Palce 10f. Zip Code 20 20 20 20 20 20 20 20 20 20 20 20 20		10g. Citizen of What (	Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturalt", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Io- 14. Race - Al White, et Specify:	merican Indian, Black, c.
5 72 hours a n "natura al Exami	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT usual occupation (Sive kind during most of working life.)	ind of work done use retired)	16b. Kind of Busine	•
0036 within iene. er tha	dmo	4 IT Professional		Compute	er
15-( filed al Hyg ed oth	Be Co		Name (First, Middle,		
212 212 ould be Ments mark	To B	Alphonso B. Gaye, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb	ricia Denn per or Rural Route Nu	I <b>İ.S</b> ımber, City or Town, S	tate, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than njury or other traumatic event, the Medica	ľ	Janneh Gaye-Adighibe/Sister 1529 W. Fairmount 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,			
ore, ss l an of Hea If iter tra		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
time L. Page tment rtant:		4 Donation 5 Other Specify: Fairfax Memorial Park			
Ball permit Depart Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Physician		7400 Georgia Ave.  Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as care	rdiac or respiratory ar	rest, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries			Between Onset and Death
and a		or condition resulting in death)  Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of):			
executed an and al - transit		events resulting in death) Last Due to (or as a consequence of):  d.			
	Physician/Medical	UNPENDED  X AMENDED #10c,e,f,perCourtOrder,G955,9/	/5/2014.WS		
760 ficate t g physi	/Me	23b. Was decedent pregnant in the		Loui Date of don	
Box 68760 s death certificate be the attending physical for use as the bu	iciar	4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month	Day Year
BO; he deat the at hed for	hys	1 Yes 2 No 9 Unknown g Unknown	1-2-2-1		
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physical page 2 should be detached for use as the buri	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		es 2 No 3 F	to the cause of death?
cords, P.C. taw requires that thas been signed to e 2 should be deta	Completed				autopsy findings available
e law r e has b ge 2 sh	ğ W			ormed? death	
Vital Rec ysician: The his certificate director, page	ပို	25. Was case referred to medical 26. Place of Death (C		2 ✓ No 1	Yes 2 No
Vita hysicia this ce	OB O	examiner?		Residence 6 Ot	her:
n of ving Ph	T:UC	27. Manner of Death  28a. Date of Injury  1 Natural 5 Pending  28a. Date of Injury  May 30, 2010  1747 hrs  1 Yes 2 V A	Motorcyclis	how injury occurred t involved in colli	sion
Sior Attend death ector: by the	catic	2 🗸 Accident Investigation	No		
Division of Vital Records, To the Hospital or Attending Physician: The law requirt within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b	ertification:	3 Suicide 6 Could not be determined (Specify) Local Street	or Town,		Rural Route Number, City  Baltimore, MD
e Hosp r 24 ho e Fune etely f	SalC	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place			
To th withir To th compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.  29b. Signature and title of certifier 29c. License number	irred at the time, date		
us		29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (i	vionin, рау, теаг)
		30. Name and address of erson who completed cause of death (Item 23a)		1	
	ł ji	Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	D 21201		
S Regis		31. Date filed (Month, Day, Year)  11 N 2.5 2010  32. Registrar's Signature  A. Sparks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 20T0 4:59 P M GOREN MYRON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** BALTIMORE 1840 REISTERSTOWN ROAD BALTIMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday 8. Date of Birth Funeral Months Hours 0571571941 69 MD 215-42-2017 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 1840 REISTERSTOWN ROAD 21208 USA items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ō 1 Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 72 hours after WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 'natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CITY OF BALTIMORE ADMINISTRATOR Be Page 1 and 2 should be filed iment of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 GOREN SCHUMAN WILLIAM LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 WESTERN SADDLE DRIVE, TIJERAS, NM 87059 CHERYL JOHNSON/NIECE other 1 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite 5 1 X Burial 2 Cremation 3 Removal from State 6/24/2010 injury o 4 Donation 5 Other (Specify) HEBREW YOUNG MEN CEM. BALTIMORE, MD 21. Signet of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS. . INC. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine ff any, leading to immedicause. Enter Underlying Due to for as a consequence of sician and burial-transit Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 9 I Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy this certificate Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 7 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? Natural iniury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2059 hite onto

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ZVealo 7-457 Gartelman, Jr. Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death en rond 5 BULN Baltimore-Washington Medical Center If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F (Month, Day, Yea / 21/1929 Country) Maryland Hours Director 216-28-0615 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Millersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 21108 423 Old Mill Rd. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Factory Worker National Plastic Be 17. Father's Name (First, Middle, Last) should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ဥ Henry Dietrick Gartelman, Sr. Margaret Angyelof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perint. Page 1 and 2 st Decartment of Health at Important: If item 27 is any injury or other trau Beatrice Gartelman / Wife 423 Old Mill Rd. Millersville, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/26/2010 <u>Glen Haven Mem. Park</u> Glen Burnie, Maryland 22, Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, MD ice License 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate obuce E. Iter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) the 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Funeral Director: After this certificate sted filled in by the funeral director, pag **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direction determined Medical 29a. Certifier stifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certific 29b. Signature 29d, Date signed (Month, Day, Year) 006 30. Name and address of per who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

CAROCIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2010 Sue Leetch Harvey Medical June 22 4:00 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Hospital Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 Months Days Hours Min. 219-34-0785 Director Month, Day, Year) 16/1935 Mary land Usual Residence of Decedent 3a or 28a-f show t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Lutherville 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1623 Trebor Court 21093 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert G. Leetch Catherine Upsher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Leetch / Daughter Bramleigh Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/29/2010 Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. Onset and Death belown stures disease or condition Hours Medical resulting in death) Due to (or a consequence of) Examiner sterie 1 cous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Month Day been signed by the should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by desen Completed 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation Could not be 1 Yes 2 No М 24 hours after deat Funeral Director; 6 ... 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Donalis D26394 10 Kei 6/24/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's signatur

N. CHARLES

BALTU

MDZIZUY

ST #450

Division or Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

or Attending death.

within 24 hours after deatl To the Funeral Director: Fo the Hospital

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Columbia Mag Cedar 334 L9211'S Lane Hnd 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

10

Medical

State

Registrar

JUN 2 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Physician/ Month DONALD E. HENDERSON SR. 17:37 рм <u>June</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Medical Center **Baltimore** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Mary land 1 25M 2 🗆 F Jun 30, 1939 216-34-6355 Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits Dundalk 1 ☐ Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? 23a East Avenue USA 2127 and Mental Hygiene. is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) atholic Cha Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 812 205th (daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Mem. Brk Jun 22,2010 6/en Burnie, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully - Polyniak Tuneral Home P.A. 21. Signature of Funeral Wice Licensee 3204 Mountain Road 23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Respiratory isease or condition resulting in death) Days Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autops\ perform death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check completed cause of death (Item 23a) (Type, Print) 4940

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Juanita Hampton 06 24 2010 5:30 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium, Maryland Stella Maris Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F 02/27/1931 Country) Maryland Director 214-28-4659 79 Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 X No Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 13803 Ansari Lane 21013 U.S.A. death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Hospital</u> Registered Nurse 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Pilkerton George Linwood Dement and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Edward F. Hampton (husband) 13803 Ansari Lane - Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State JUNE 4 Donation 5 Other (Specify) St.John Luth.-Blenheim 6/26/2010 | Long Green, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 000 <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1ETASTAT Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🕱 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practionar. To the best of my knowledg 29b. Signature and tit 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registra's Signa Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		I- For State Registrar		Certi	ficate of l	Death		Reg.	No.	
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle, I	ast) Ha	cc				June 13, 201	ay Year 10	3. Time of Death 0901 hrs
		<ol> <li>Facility Name (if not institution, Johns Hopkins Hospital</li> </ol>	give street and number)		4b	. City, Town, Baltimore	or Location of Deat	n .	4c. County of Death	<del>)</del>
Funeral Director		219-52-549	Sex 7. Age (	In yrs. last	t birthday) Yrs.	If Under 1 Y Months D	ear If Under 24Hr ays Hours Mir		MM/DD/YYYY) 9. Bit - 1950 Foreign	
Aaryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a. State  10b. County	J/A 10	Oc. City, To	own or Location	et	more	1100	. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
the Mary 3a or 28a	Director	10e. Street and Number  2019E, A	1 orth	ar	e	10f. Zip Code	2120	2	V_S	A
ter death with	Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divor	ied	ver in U.S.	If Yes	, specify Cut	Hispanic Origin? ( Span, Mexican, Puerto No specify:		14. Race - Amer White, etc. Specify:	ican Indian, Black,
36 n 72 hour ian "natu ical Exan	Completed by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	or Dates:		during mos		pation (Give kind of life. DO NOT use ref		6b. Kind of Business/	Industry Rases
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	Be Com	17. Father's Name (First, Middle, La	ist)	7 1	Hal	l		e (First, Middle, Mai	iden Surname)	)
D 21 should and Me 7 is ma	ToB	19a. Informant's Name/Relationship	(Type, Print) - Sis	ter	19b. Mailing	Address (St	reet and Number or	Rural Route Number	er, City or Town, State	e, Zip Code)
of H		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec			ace of Dispositi ematory or othe		cemetery,	Date 2 2010 d	20c. Location - City or Ocendal	RimD.
Baltimo permit. Pag Department Important: injury or or	ļ	24. Signature of Funeral Service Lie	censee Cereloe	e	Na	na	ess of Facility 3	405 w.		md. 21270
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Box 68760, e death certificate be the attending physic ed for use as the bur	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at tin  9 Unknown		2 Feta	death (Specify)	3 Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year
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Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate by the surface death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1	Completed I	Chronic obstr renal failur		-	diseas	e, chi	ron1c	24a. Was an autopsy	24b. Were a prior to death?	utopsy findings available completion of cause of
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Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	2 Accident Investig 3 Suicide 6 Could independent 4 Homicide	28e. Place of Injur	ry - At hom	ne, farm, street,	factory, offic	e building, etc.	28f. Location (Stre or Town, Stat		ural Route Number, City
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or P o	Me	29b Signature and little of certifier	ter Velk	Ind	50		ense number C.M.E.		29d. Date signed <i>(Mo</i> June 14, 2010	onth, Day, Year)
		30. Name and address of person w Victor Weedn MD JD	ho completed cause of dea Assistant Medical E			nn Street	, Baltimore, MD	21201		
St Regist		31. Date filed (Month, Day, Year)	2010 32. Registrar's	Signature	A. So	. Nel				

DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10g, per Fh g904/6/25/10 TT/ #2015 per FH G904/6/3010, WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5402 9!33A M Medical 4b, City, Town, or Location of Death 4c. County of Death Examiner Himore 8. Date of Birth (Month, Day, Ye Oct. 26, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Hours Virginia Director 1945 64 460-86-4013 Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland Director 1 Tes 2 X No Forest Hill Maryland Harford 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 21050 2199 Sewanee Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 XYes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No x; 3pecify. and Mental Hygiene. Specify Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Leak Specialist Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Anna Vandavender Charles Wesley Houff Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 219 Wheeler School Rd., Pylesville, MD 21132 Sherry Westerman/ POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Service Corp Signature of Fun Service Licenset 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) brain herniation Medical Due to (or as a consequence of Examiner hemorphagic Sequentially list conditions, Examine Due to for as a consequencause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica Division of Vital å 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie P23086 MD 30. Name and address of person the completed cause of death (Item 23a) (Type, Print)
Suranne Sefert (ON) ONORTH GREENE STREET Baltimore MD 2129 31. Date filed (Month, Day, Year) 32. Registr s Signature State

DHMH 17 Rev 7/2009

Registrar

AMEND 1 TEM#19b, perFH, G905, 7/2/2010, WS State of Maryland, Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year Flowers Geneva Hockaday 3:44 A M 6 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 💥 🗆 F Months Days Hours Min Yonth, Day 240-52-9081 Director 78 NC Usual Residence of Decedent show 3a or 28a-f shov t be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must 1050 East 33rd Street #408 21218 U.S.A. ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2√☐ No Specify: "natural", Black 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade Domestic Worker Private na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Flowers Bettie McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Monica Hockaday-Daughter Christopher Ave, Baltimore Baltimore, 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Donation 5 Other (Specify) Glenview Memorial: 6/26/2010 Dunham, NC . Signatura of Funeral Service Lice 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death †Hysician disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 24 hours after death. Funeral Director; After this certificate I 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1-Natural injury 5 Pending Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D69540 22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) swib 204 Parkville MD 21234 State Registrar

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DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Fun Dire permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 Ph sic Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760

	_	1 - State Registrar				Ce	rtificate of	Death		Reg. No. 2010 19916				
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amin	er '	4a. Facility Name (if	not institution, g	jive street and nun	nber)		4b. City, Town,	or Location of De	ath		4c. Count	y of Death		
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DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Margaret Genevieve Koster June 24. 2010 2:50 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Months 1 □ M 🕱 🕽 F 158-03-0530 26, 1917 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Maryland Millers Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5303 Grave Run Road 21102 America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes XXNo Specify: 3℃XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hampstead Elementary/Secondary (0-12) College (1-4or 5+) 12th Seamstress Sewing Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Homer W. Kline Genevieve Kline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Koster (Son) 5303 Grave Run Road, Millers, Maryland 21102 20b. Place of Disposition (Name of Acametery, crematory or other place) All Faiths Crematory & Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition June 25, 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Manchester, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one property on each inc. Approximate Interval Between Onset and Death iate Cause (Final disease or condition resulting in death) enseles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

72 hours after death with the Maryland

/Medical

10a, State

Director

Funeral

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Completed

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requires that the death certificate be executed burial-trar attending physician for use as the buria Division of Vital Records, P.O. Box 68760 signed by the a has Physician:

Hospital or Attending

within 24 hours a

To the Funeral

completely

Examine Physician/Medical þ director, page 2 should Completed certificate Be Certification: To After this funeral after death. filled in by the

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 Ectopic			23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
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25. Was case referred to medical			26. Place of De	ath (Check only one)			
examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	Home 5 ☐ Residence	6 ☐ Other (Specify)			
27. Manner of Death  ↑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju			
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory)	28f. Location (Street a	28f. Location (Street and Number or Rural Route Number, City or Town. State)			

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie one and manner stated 29b. Sign and title of certific

29c. License number

31. Date filed (Month, Day, Year) State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nend #8 per FH G905 7/1/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DANIEL JOSEPH KNIGHTON Jumenth 22, 2010 Year 8:26P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium . Social Security Number If Under 1 Year 7. Age (In vrs. last birthdav) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 XXM 2 🗆 F Days Min. 01/10/10201920 Director 214-18-2245 90 Yrs Mary Tand Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XXNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8830 Walther Blvd 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Tillie Mika Daniel Vernon Knighton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dtr/POA 5 East 39th Street Baltimore, Maryland 21218 Cathie Knighton Dear 20b. Place of Disposition (Name of cemetery, crematory or other place)
GreenMount Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 06/25/2010 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition DEMENTIA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 2 🗆 No 1 TYes 25. Was case referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1X Natural 5 Pendina 1 🗌 Yes 2 🗌 No М Accident Investigation within 24 hours after deat To the Funeral Director: 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and itle person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES. TIMONIUM, MD 21093 Date filed (Month, Day, Year) State JUN 25 2010

DHMH 17 Rev 7/2009

Registra

UNE 22,

DANIEL KNIGHTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Book Sil Kim 2:54 P Jun 22, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Randolph Hills Nursing Center Wheaton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Hours **Funeral** 1 M 2 F HOTEG 96 146-54-5145 Director Jun 10, 1914 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other treumatic event, The Madical Eventiest must be rudified ut once. 1 Yes 2 No MD Wheaton Funeral Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4011 Randolph Rd. 20902 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Specify: Korean 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be unknown unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy K Cheng, daughter 535 Wayland Dr. Hockessin, DE 19707 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doration 5 ☐ Other (Specify) Jun 26, 2010 Wilmington, DE All Saints Cem. e of Funeral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0535 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. art1. Enter the disease List only one cause on nediate Cause (Final Pnysician ease or condition sulting in death) /Medical Due le lor as equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit P.O. Box 68760,  $\[ \[ \] \]$ Due to (or as a consequence of): as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 mon ó 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 Unknown 1 ☐ Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 21 1 Yes certificate Division of Vital To the Hospital or Attanding Physician: 26. Place of Death (Check onl one 25. Was case referred to medical examiner? Be Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 10 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death Certification: 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death. naral Diractor: A filled in by the ft investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and addre

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 2 5 2010

Jensey B. Jan

s of person who completed cause of death (Item 23a) (Type, Print)

B. park

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		1- For State Certificate of De	-	Reg. No	2010 19920		
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) WILLIAM WAYNE KRAUSE		2. Date of Death Month Day June 19, 2010			
*		4a. Facility Name (if not institution, give street and number)  4b. C	ity, Town, or Location of Death ddle River	4	Ic. County of Death Baltimore County		
Funeral Director		212-52-1466   1X M 2 F   63 Yrs. M	Under 1 Year If Under 24Hrs. onths Days Hours Min.		947 Solution (State or Foreign Country) MD.		
vfaryland 28a-f show any 1 at once.	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore 10e. Street and Number 10e.	Baltimore Co		10d. Inside City Limits  1 Yes 2 No itizen of What Country?		
the Ma 3a or 28	Dire	9759 Bird River Rd.	21220		USA		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examing: must be notified at once.	y Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No specify:		14. Race - American Indian, Black, White, etc.  Specify: White		
hours a natura	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Utilities most or	sual Occupation (Give kind of w working life, DO NOT use retir		Kind of Business/Industry		
036 tthin 72 ne. r than "	Completed	12 yrs. College (1-4 or 5+) N/A Steel Wo	rker	Ве	thlehem Steel		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examine.	Be	17. Father's Name (First, Middle, Last) George Krause	Thelma T				
MD 2. 2 should h and Mu 27 is ma imatic c	۲ ۲		ress (Street and Number or R Ave. Essex, M		City or Town, State, Zip Code) 21221		
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.		20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from State  Comparison Formula Comparison Form	Name of cemetery, ace) rest Cem. 6-2	1	Location - City or Town, State		
Baltimo permit. Page: Department o Important:		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name Lass	and Address of Facility ahn Funeral Ho		Belair Rd. More, Md. 21236		
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mortalities. List only one cause on each line.	ode of dying, such as cardiac or		nock, or heart Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Cirrhosis of liver  Due to (or as a consequence of):			Death		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
uted id ansit	Examiner	(Diesess or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	, , , , , , , , , , , , , , , , , , ,				
), be executed sician and urial - transit	dical	UNPENDED AMENDED					
Box 68760, te death certificate be the attending physici and for use as the burined for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (			3d. Date of delivery Month Day Year		
• 4 × 5		Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.		o use contribute to the cause of death?  No 3 Probably 4 Unknown		
Records The law requicate has been page 2 should	Completed by			24a. Was an autopsy performed?			
Vital Rechysician: The this certificate	o Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check of DOA Other Nursing		dence 6 🗸 Other: Scene		
ion of Vital   trending Physician: Jeath. tror: After this certifi the funeral director,	_ <u> </u>	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how in			
Division ospital or Atte hours after des uneral Directory filled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, fact (Specify)	tory, office building, etc.	28f. Location (Street or Town, State)	and Number or Rural Route Number, City		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Directors completely filled in by the	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, i and manner stated.					
F % F 8	Me	29b Signature and title of certifier  Moment The Krull	29c. License number O.C.M.E.		Date signed (Month, Day, Year) ne 20, 2010		
		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2	21201			
S Regis	tate	31. Data filed (Month, Pay Year) 32. Registray's Signal fre					

Registrar

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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9000 FAANKLIN Square DR Balto md

6-22-2010

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Koea 1345 M 3010 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Patterson Avenue Cumberland Alleagn 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 217-10-7746 Director 12-04-1915 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinan must be notified at Director Mg 1 ☐ Yes 2X No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? atterson Avenue USA 31503 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify \$ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 contract writer board of education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Shilland Harvey Katherine Jardine ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Truter - daughter 236 Nottingham; Annapolis, Maryland 21405 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wade <sup>22.</sup> State Anatomy Board; 655 West Baltimore Street win Baltimore, Maryland 21201 23a. Part1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca . e Final disease or con ...lon resulting in death) Physician TUOVIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending I IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mo Month Day Year 5 ☐ Other (specify) ed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician; The certificate performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 [] N : After this certificat e funeral director, pr 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1∐ Yes 2 Other: 4 Nursing Home 5 Desidence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 5 Pending n 24 hours after death.

e Funeral Director: Af 2 Accident investigation 1 🗆 Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie completely (Check only one) within 2 the 29b. Signature and title of certifie PITYSICAN

State Registrar 30. Name and

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

ORIGINAL

912 STON DILIVE CUMBERLAND, MY)

address of person who completed cause of death (Item 23a) (Type, Print)

- WVERIA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland		rtment of F tificate of D		nd M	, ,	201	n	19923
			Registrar  1. Decedent's Name (First, Middle, La.	st)		OCI	uncate or L	Jean		2. Date of Deat	eg. No		3. Time of Death
	Physicia		Sylvia	Levy						June	22 <sup>pay</sup> 2010	ear	6:00 P M
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town, or	Location of	Death		4c. County of		0.00 -
			Manor Care Potom	ac			Poto				Montgomery		
	Funeral		Social Security Number 6. S		e (In yrs. last	birthday)	If Under 1 Year	If Under 2		8. Date of Birth		J. Birthp	lace (State or Foreign
	Director		133-26-3761	□м 2 🖾 F	98	Yrs.	Months Days	Hours	Min.	June 7,	<sup>Year)</sup> 912	Net	W York
	nd now	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					L	
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	or 28; notif	Director	Maryland Montgom 10e. Street and Number	ery		Poto	nac 10f. Zip Code						1 Yes 2 No
	vith th	<u>ra</u>	11005 Riverwood	Drive				0854			0g. Citizen of Wh		
	ems r mu	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. W	as Decedent of Hi	_	n? (Spec	cify Yes or No-	United		
စ္တ	or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐	<b>₫</b> No	lf lf	Yes, specify Cuba	n, Mexican,	Puèrto F	Rican, etc.)		White, e	
ဗ္ဗ	urs af ural" Il Exa	ed	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1	∐Yes 2x No	Specify:			Specify:	Wh:	ite
5-	"nat	Completed	15. Decedent's E (Specify only highest gr		1		ent's Usual Occupa ind of work done d		of workin	na l	16b. Kind of Busin	ness Ind	lustry
12	thin 7	팃	Elementary/Seconday (0-12)	College (1-4 or 5	· 1 .	life. DC	NOT use retired)						
2	ed wi	Be (	17. Father's Name (First, Middle, Last)		1.5	Secre	tary / Ho	memak			Import/E	XDOI	ct /Own Home
a	be fill ental ked c	인	David Dworkin					_		(First, Middle, M	aiden Surname)		
3	nd Mid mar marti	2	19a. Informant's Name/Relationship (T			10b Mailin	Address (Street a	An And Mumber		Lewis Double	City on Town Chat	- 7:- 0	- 4-1
ž	12 shall ha 27 is 27 is r train	0.00	Marilyn Hardis/d				Riverwoo						
ē,	1 and of Hear item		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name of				20c. Location - Ci		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene.  In marked other than "natural", or items 23a or 28a-f show mortorant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	l Removal from State (y)			atory or other place		6/2/	/2010	Woodbine	M-	bacland
att	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	S ( )	диц	22.	Name and Addres	s of Facility	0/24	- Co	D.O	, I'IC	704
<u> </u>	89 = 89		Juanta (X)	homas	M0095	57 B	Name and Address Ding Home Everly L.	Heck	rott	n servi e, P.A.	ce P.O. Clarksv	BOX ill€	/84 e, MD 21029
			23a. Part 1. Enter the disease, or company of the shock, or heart failure. List only o	olications that caused ne cause on each line	the death. D	o not enter	the mode of dying	, such as ca	ardiac or	respiratory arres	st,		Approximate Interval Between
<b>J</b>	Physician/		Immediate Cause (Final disease or condition	Sepsis									Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a		ce of):			***			$\top$	
		e.	Sequentially list conditions,	Pneumo									
	sit st	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a consequenc	ce of):							
	ecute and I-tran	Exa	that initiated events resulting in death) Last	C. Due to (or as a	a consequenc	ce of):						+	
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Division of Vital Records, P.O. Box 68760	ficate g phys	ledi		d									
89	ath certific attending p for use as	Physician/M	Lob. 11db debedont program	23c. If yes, outcome			F.1. 1				23d. Date of	f deliver	rv
õ	death e atte	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant at			Ectopic pregnancy Other (specify)	/			Month		Day Year
	t the o	'n.	9 ☐ Unknown	9 ∐ Unknown									
<u>o</u> .	requires that the de been signed by the should be detached	۾	Part II. Other significant conditions co		ut not resultin	ng in the un	derlying cause give	en in Part I.		23e. Did tob	acco use contribu	te to the	e cause of death?
g	aguire sen si ould	ted	Parkinson's Disea	ase						1 ☐ Ye	s 2 🗆 No 3	Prob	ably 4 🔀 Unknown
ᆼ	law re nas be	Completed								24a. Was an		e autop	sy findings available apletion of cause of
8	sician: The law is certificate has birector, page 2 s	ខ្ញុំ								perform 1 Yes 2	ed? dea		2 🗆 No
ta	ysician; lis certifi director,	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	(Check	only one)			
<u>_</u>	Phys this	임	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatie	ent 2 ER/	Outpatient  o. Time of		4 X Nurs			ce 6 Other (S	pecify)	
0	ding th. After fune	sate	1 X Natural 5 ☐ Pending	(Month, Day	Year)	injury	28c. Injury work? M 1 🗆		- 1	3d. Describe hov	injury occurred		
200	Atten r dea ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	rv - At home.	farm, stree		res Z 🗆 N	-	Rf Location (Str	eet and Number o	- Dumi I	Pauta Number
N	al or al or		4 ☐ Homicide determined	building, etc	. (Specify)		n, rabioly, ombo			City or Town,		nurair	noute ivalliber,
	ospit hour unera	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledg	e, death oc	cured at the time,	date and pla	ace, and	due to the cause	e(s) and manner a	s stated	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 Certifying Nurs	<b>ner:</b> On the basis of ex	camination and	d/or investic	iation, in my opinior	death occu	irred at the	he time date and	place, and due to	the caus	se(s) and manner stated
	5 1 × 5 0		29b. Signature and title of certifier	160		1.1	29c. License			29	d. Date signed (M	onth, D	ay, Year)
			- Kali	vow	7-1	1	D20	274			June 2	23,	2010
			30. Name and address of person who c										
	Char		Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)	7710 Bra	dley B	lvd.	Bethesda	a, Mar	ylaı	nd 20817	<u></u>		
	State Registra	~		news A.									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Land wehr Louis 2010 12:55 a M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel I a Casa De Rosa Nursing Center

5. Social Security Number 6. Sex <u>Linthicum</u> 8. Date of Birth (Month, Day, August 30, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 1 ■ M 2 □ F Mary Land 215-28-3356 79 August Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director Brooklyn Park Maryland Anne Arundel 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21225 U.S.A. 5703 Pope Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Marvland Drydock traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, and Mental Fishers of Section 1 ည permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Louis W. Landwehr Madeline Squires 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 102 Sixth Avenue N.E. Glen Burnie, Maryland 21060 Daniel C. Conkling (attorney at Law) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery June 26, 2010 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21122 21. Signature of Funeral Service Licenses 23a. P. 1.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cluster on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ Cancer isease or condition una Medical resulting in death) Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant 9 Unknown Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 □ robably 4 □ Unknown 1 🗌 Yes 2 No Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5  $\square$  Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie ns Rajapahrem. D D0057465 6/24/10 Teath (Item 23a) (Type, Print) AV-5-235 Baltimore, MD. 2120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-5. RAPAKSE/M'D Z835 S MIM 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robertta P. June 2010 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16025 Pheasant Ridge Court Woodbine Howard 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 X Months Days Hours July 12, 1923 **Director** 177-16-6340 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. or 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Howard Woodbine 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16025 Pheasant Ridge Court 21797 USA 12. Was Decedent Ever in U.S. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2X No 1 ☐ Yes 2 👿 No Specify 3 🔽 Widowed 4 🗆 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Wir<u>er</u> Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Walter Piper Marie Duffy 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kelley L. Serdenes 16025 Phesant Ridge Ct., Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 6/25/2010 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee MOOTEH Hay PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final PULMONARY DISEASE Onset and DeRh S Physician/ CHRONIC OBSTRUCTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year been signed by the a should be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HUPERTENSION Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CEREBROVASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed? Yes 2.2 After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home Residence 6  $\square$  Other (Specify 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title JUNE 22, 2016 30. Name and address of person who cometed cause of death (Item 23a) (Type, Print) GLENWOOD MAURER MO

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

32. Registrar's Signature

RT GT

SUITEID

			State of Maryland / Department			_	10026	
		-	FOR	tificate of Death		g. No.	19926	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physicia Medic		Theodore Delbert La Barre,	Sr.	Month June	23, 2010	07:05 P M	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
- ^			Somerford Place	Columbia		Howard (		
	Funeral Director		5. Social Security Number 215-09-2146 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y Feb. 20	(ear) Coun	place (State or Foreign htry) cyland	
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		F	10d. Inside City Limits	
	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	Maryland Anne Arundel Co. Severn				1 🗌 Yes 2 🔀 No	
	or 28	ä	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?	
	s 23a	era	1206 Reece Road PO Box 49	21144		United Sta	ites	
	death item		11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 13. Value 1 No	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
36	after	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2X No Specify:		Specific	White	
8	atura cal E	ete		dent's Usual Occupation		6b. Kind of Business In		
215	an "n Medi	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work O NOT use retired)	ing	ob. rund of Doomlood in		
21215-0036	e filed within 7 tal Hygiene.			ol & Dye Maker		Western H	Electric	
pu	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma			
yla	should be file n and Mental h 7 is marked o raumatic eve		John La Barre	Elsie	Conwa	<u> </u>		
Maryland	shou h and 7 is n traum			ng Address (Street and Number or Rura		•		
e,	and 2 Healt em 2		Mrs. Patricia A. Bussey/Daughter 12  20a. Method of Disposition 20b. Place of Dispos	206 Reece Rd. PO		Severn, MD		
Baltimore,	age 1 ant of t: If it		1 Burial 2 Cremation 3 Removal from State cemetery, crei	natory or other place)				
∄	nit. P.		Borrarie	Park Cem. 96/28 2. Name and Address of Facility Sin		Woodlawn, N	-	
B	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev			ervices, PA; 1 2nd				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
	Physician/		Immediate Course /Final	FARCTION			Onset and Death ONE WEEK	
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):					
	LAUIIIIICI	<u>.</u>	Sequentially list conditions, b.					
	ed sit	Examiner	If any, leading to immediate  Due to (or as a consequence of):  Cause Erber Underlying  Cause (Disease or injury)					
	be executed sician and burial-transit	Exa	that initiated events c.  resulting in death) Last Due to (or as a consequence of):					
0	s be e	ical	d					
376	ificate ig phy as the	Med	IF FEMALE:					
۵ ×	h cert rendir r use	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv	•	
Box 6876	death	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death 5 D	Other (specify)		Month	Day Year	
P.O.	at the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?	
S, F	signe d be (	d by	CORONARY ARTERY DISEASE		1 🗌 Yes	s 2 XNo 3 Pro	bably 4 Unknown	
ord	requipers	ete	CONGESTIVE HEART FAILURE		24a. Was an		ppsy findings available	
ec	ne law te has age 2	Completed	CONGESTIVE MEANT TAILORE		autopsy perform		ompletion of cause of	
al F	an: T tifical tor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec				
<u>X</u>	hysic lis ce	은	1 Yes 2 No 1 Inpatient 2 ER/Outpatie			ace 6 X Other (Specif		
10	ing P	ate:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe hov	v injury occurred	Living	
io	ttend death stor: A	tific	2 Accident Investigation 3 Suicide 6 Could not be 4 Nonicide 6 Suicident 28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	28f Location (Str	eet and Number or Rura	al Route Number	
Division of Vital Records,	after Direc	Se	4 Homicide determined building, etc. (Specify)	eet, factory, office	City or Town,		irridate rvattibei,	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, at	nd due to the caus	e(s) and manner as state	ed.	
	he Ho in 24 he Fu iplete	Med	(Check 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a death occurred at the time, date and pla	t the time, date and ce, and due to the o	place, and due to the ca cause(s) and manner as s	ause(s) and manner stated. tated.	
_	To t		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,		
	)		, hit	D56531		June 24,	2010	
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Harry Li, M.D. 8600 Snowden River		01, Colum	nbia, MD 21	045	
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrats Signative					
	Registr		31. Date filed (Month, Day, Year)  JUN 2 5 2010  32. Registrate Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 201<u>0</u> Physician/ John Edward Larmore June 22 9:31P М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
April 2, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 **X** M 2 □ F 214-12-6638 89 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Silver Spring Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 3611 Adams Drive 20902 permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces 2 1 Never Married 2 X Married 2 No X Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates, WWII Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Layer Masonry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Annie E. McGrath Roy E. Larmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3611 Adams Drive, Silver Spring, Maryland 20902 Rosie A. Larmore/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of June Day 6. Parklawn Memorial Park 1 X Burial 2 Cremation 3 Removal from State  $\bar{2}\bar{0}1\bar{0}$ Rockville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville; Inc. 1300 West Montgomery Avenue 21. Signature of Funeral Service Licenses M01498 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Stroke Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ned by the atter Month Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performe 1 ☐ Yes 2 ☐ No certificate 2X No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural injury work? 5 Pending 2 🗌 No Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my month of the cause of the time, date and due to the cause(s) and manner as stated. сопретер (Check within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00052586 atel Layenti 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti Patel, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State alla Registrar UN 2 5 2010

DHMH 17 Rev 7/2009

10-04654									
Javme	Maranto								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jayme Maranto		State of Maryland / Department of the For State Certificate of Registrar			201 Reg. No.	0 19928
Physiciar Medical Examin		1. Decedent's Name (First, Middle, Last)  Jayme Lynn Maranto		2. Date of De Month June 20,	Day Year	3. Time of Death 1300 hrs
1		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Death Rosedale	า	4c. County of De Baltimore C	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 45	If Under 1 Year If Under 24Hr  Months Days Hours Mir		irth(MM/DD/YYYY) 9. Fo 27.1964	Birthplace (State or reign Country) DC
/aryland 28a-f show any Lat once.	ō	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 Yes 2 No
the Maryl a or 28a-l	Director	10e. Street and Number 9471 Seven Court Drive	10f. Zip Code 21236		10g. Citizen of What C	ountry?
	by Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:		o- 14. Race - An White, etc Whi Specify:	nerican Indian, Black, c. te
1036 within 72 hours iene. er than "natur Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during r 1 2 Book	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret	ired)	16b. Kind of Busine	ss/Industry
21215-0036 tould be filed within 7 de Mental Hygiene is marked other than tic event, the Medica	8	17. Father's Name (First, Middle, Last)  Errol Randolph Poetzman  19a. Informant's Name/Relationship (Type, Print )  19b. Mailir	18.Mother's Name Roberta g Address (Street and Number or I	a Gam	Maiden Surname)  arsh mber, City or Town, St	ate, Zip Code)
		1 Burial 2 Cremation 3 Removal from State crematory or o			rry Hall 20c Location - City Beltsv:	
		2) ignature of Funeral Service Licensee MO1443 222.	Name and Address of Facility CAF 717 Green Past	TA/Ste	phen D. I Dr. Balto	Cohrmann, PA
Physician /Medical Examiner		23a. P. 1. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic call Due to (or as a consequence of):			rest, shock, or heart	Approximate Interval Between Onset and Death
ed Issit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):				
be execusician and ourial - tra	edical	MUNPENDED AMENDED 23a,27, PII, pe 1	ME g905 7/15/10	TT		
Sion of Vital Records, P.O. Box 6876( Attending Physician: The law requires that the death certificate death. evetor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the by the funeral director, page 2 should be businessed.	ΣΙ.	35. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna her (Specify)		23d. Date of deliv Month	ery Day Year
ires that the signed by the detached by the detached by the detached by the detached by the betached by the be	6	Part II. Other significant conditions contributing to death but not resulting in the Cirrhosis of the liver	underlying cause given in Part I.		obacco use contribute s 2 No 3 P	to the cause of death?  robably 4  Unknown
tal Records cian: The law requi certificate has been ector, page 2 should	Completed			1 ✔ Yes	prior to pri	autopsy findings available o completion of cause of ? Yes 2 No
Division of Vital Records, tal or Attending Physician: The law require attending Physician: The law require attendent After this certificate has been silled in by the funeral director, page 2 should be attitication: To Be Committed	<u> </u>	25. Was case referred to medical examiner?  1 Ves 2 No  27. Manner of Death  1 X Natural 5 Pending	njury 28c. Injury at Work?	g Home 5	Residence 6 Oth	ner:
Divi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, stre	t, factory, office building, etc.	28f. Location ( or Town, S		Rural Route Number, City
DIVI To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occu one) 2 ✓ Medical Examiner: On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occurred a			
		29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (A June 21, 2010	flonth, Day, Year)
	1		Penn Street, Baltimore, MI	D 21201		
Stat Registra		31. Date filed (Month, Day Year) 2 5 2010 Registra's Signature	back	0.1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ <sup>D</sup>2010 June 22, 9:20 P M Μ. Munafo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 405 Chapelwood Lane Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 564-22-1539 1 🗆 M 2 🔀 F 90 Director 12-12-1919 Nebraska Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland | Baltimore Lutherville 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Chapelwood Lane U.S.A. 21093 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Smith Frederick Herrmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Chapelwood Lane Lutherville, Maryland 21093 Joann Koch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 【X Other (Specify) Dulaney Valley Mem. injury or 6/26/2010 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Euperal Service Lic 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINEMA 8 NKLTH Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should ' 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 Tyes 2 🗷 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Tipe, Print) Drive Suiteziz touson 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Earl Henry Miller 2010 June 11:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carrol] Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Days Hours Min. (Month, Day Year) Feb. 24, Maryland 214-16-1255 94 1916 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes XX No Maryland Carroll Millers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States by Funeral 4109 Millers Station Road America Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Was December Armed Forces?

✓ Yes XX No Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Laborer Shoe Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna A. Henry Lawrence Herman Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4109 Millers Station Road, Millers, Maryland 21102 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tt Earl R. Miller (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date June 26, XX Burial 2 ☐ Cree ation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Millers Church Cem. 2010 Millers, Maryland Signature of Fun Service Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. JEKMau 3296 Charmil Drive, Manchester, Maryland 21102 Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month n signed by the a 2 🗌 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform death? 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1. Natural 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner. On the basis of examination allows investigation, in the property of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Lee Mullinix 2010 23 10:50a M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 5. Social Security Number 6. Sex 1 X M 2 □ F Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth MD Country) (Month, Day, Year) Feb 20 1947 219-44-5391 Months Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Carroll Sykesville 28a-f 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 21784 23a 6313 Georgetown Blvd. D 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1968 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) excavator heavy equipment 1 and 2 should be filed wi of Health and Mental Hygi Fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ပ Francis Webster Mullinix Betty Jane Pickett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather N. Mullinix (daughter) 6313 Georgetown Blvd. D, Sykesville, MD 21784 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pag Departmen Important: It any injury or All County Cremation 6-26-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PULMONARY OISPHIP CHRONIC Physician/ disease or condition 24ears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has performed death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No after death

Director: A

in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurs only one d at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/23/2010 DB1660 SCREWED 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 THOMAS K-GALVI ma STONER AUBNUR WESTMINSTER MAKELING 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JUN 2 5 2010

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JM99 21, Day 010 Year Josephine Morales 7:42 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ē Shady Grove Adventist Hospital Rockville Montgomery 4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Days 577-58-6143 91 Months Hours June 25, 1918 Mexico Director Usual Residence of Decedent UNE shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27 is marked odther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13523 Grenoble Drive 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc Yes 2 No Yes, Give 1 Never Married 2 Married MORAL \$ Baltimore, Maryland 21215-0036 Specify: White 1 X Yes 2 ☐ No Specify: Mexican 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ice Cream Store Manager Be 17. Father's Name (First, Middle, Last) DOEPHING 18. Mother's Name (First, Middle, Maiden Surname) Austreberto Morales Mamalia Yescas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarahy Pena/Daughter 13523 Grenoble Drive, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 25. 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Montgomery or other plant of the crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) 2010 Fumphrey Funeral Home/ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Rockville; Inc. 300 West Montgomery Avenue Maryland 20850 M01498 M01498 Rockville; Maryland 20850<sup>TM</sup>

23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pheumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ þe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performe death? 1 ☐ Yes 2 🗷 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 **X**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. Accident Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director, completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 🗀 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 64502 June 21, 2010 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p CARPENTER 9901 Medical Center Drive, Rockville, Maryland 20850 BRIAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9, 10d, g, 12, 15-20c, 22 per FH, G905, 7,6/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1010 EANOR MUEL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SILVER 2039 SPRING MONTGOMERY Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country Washington, IX 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M Months Hours (Month, Day, Ye Director 216-58-551 6  $\mathbf{C}$ Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Ves 2 X No KENSIA 1070V 10e. Street and Numbe 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 089 24 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. .0 1 Never Married 2 Married Completed by 1 Yes 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", 3 Divorced 4 Divorced Year or Dates. 41W14 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Micdical Eonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Federal Covernment College (1-4 or 5+) Supervisor WWW. M W M 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Hall Mueller Elizabeth Ann Hechmer 19a. Informant's Name/Relationship (Type, Print)
Anthony J. Horos/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14624 Settler's Landing Way Gaithersburg, 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 Hother (Specify) in state Montgomery Crematorium 7/3/2010 ,Maryland Rethesda 22. Name and Address of Facilit Robert A. Pumphrey Funeral Home/Rockville State Anatomy Board; 553 West Religious Street Baltimore, Maryland 21201 80 W. Fortgomery Aves 50 300 W. Mootgomery Avers Rockville ND 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condin n resulting in death) Onset and Death Physician ACUTE RESPIRATORY FAILURE Medical Due to (or as a consequence of) Examiner MONAR Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit Physician: The law requires that the death certificate be executed ONGRSTIVE FORILURE and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical SLEEP BUNER P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown the detached 9 Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, ASTHMA Completed 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si; completed filled in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 Yes Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After work? 1 Yes 2 No 1 Natural injury 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practionar: To the best of my investigation, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63639 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POTHU NACABHRU 1500 FOREST GLEN RD 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GZS AM TILNE Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE UNUDRISITY OF MARRYLAND WESICAL CENTE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F 79 Months Davs Hours Min. 8 470- 930 Country) 212-28-5082 MD Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Brooklyn Park MD Anne Arundel 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21225 USA 515 Bon Air Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: white Yes. Give 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Blanche Burkhart James J. Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Bon Air Ave. Brooklyn Park MD 21225 Frances C. Felluca/daughter 20b. Place of Disposition (Name of cemetery crematory or other place)
Holy Cross Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6/28/2010 Brooklyn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician NTRACEREBRAL HAMORRIAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 Fetal dear in the past 12 months?
1 Yes 2 No Year Day Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

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and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1.25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** ARUNDE 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Funeral g(Month, Day, Year) Months Davs Hours Country) - NASYL VANIA Director Usual Residence of Decedent 10b. County 10d. Inside City Limits or 28a-f sho 10a. State death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1944-46 1 ☐ Yes 2 ☑ No Specify: WhITE Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) LECTRICA. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 25-10 YENTON. 21. Signature of Amoral Service Licenses 22. Name and Address of Facility FUNERAL HOME 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. CELL CANGER OF THE LUNG QUAMOUS Onset and Death Immediate Cause (Final Pnysician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a conseductice of signed by the attending physician and dbe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy perform Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<sup>Day</sup> Bernard W. Neff Physician/ 2010<sup>a</sup> June 4:54p Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Jan 29 ay, 1 🗓 M 2 🗆 F 219-26-6839 71 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Carrol1 Sykesville 1 🗆 Yes 2 🖰 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2314 Erin Road 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mea any Injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) printer printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis G. Neff Agnes Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Neff (spouse) 2314 Erin Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Meadowridge Memorial 6-24-10 Elkridge, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Darge Spaight I P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a d be detached f Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PerebrovAscular 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy page death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 7 No ၉ 1 Yes POSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Varse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confide 29c. License number 29d. Date signed (Month, Day, Year) 010 020806 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21136 Business ENR 31. Date filed (Month, Day, Year)
JUN 2 5 2010 32. Registrar's gnature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Nichols Marie Rose Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death Examiner Anne Washington M 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Hours Min. (Month, Day, Year, Country) 74 PA Director 219-30-0685 07-14-1935 Usual Residence of Decedent 10b County or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Sycamore Road 21090 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event at a conce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Law Firm Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Richards Patricia Ambrose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Sycamore Road 21090 Ms. Lynn Marie Nichols/Daughter Linthicum, MD20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 06-25-2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicianz 2 disease or condition Medical resulting in death) Due to (or as/) consequence of) Examiner Sals MIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Year Month Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 1 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Aatural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check d, title of certifier 29d. Date signed (Month, Day, Year) 010 251 MINE R.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May **Physician** 193 ŹĈĨ0 9:50 Helen Nichols /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Harmony Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 25, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year 20 1 □ M 2 🙀 F Massachusetts 89 **Director** 147-10-6393 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment mater the medical song. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Columbia Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 6336 Cedar Lane; Apt 315 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White If Yes, Give Year or Dates: ρ 3 X Widowed 4 □ Divorced 1945 Completed 16b. Kind of Business/Industry una 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chef 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Sleceka Felix Kresla မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Homestead Road; Lake Hopatcong, NJ 07849 Rosemary Martin - daughter Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Arvice S. Wade 22. Name and Address of Facility Board; 655 West Baltimore Street irector Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in death) Disease heimers **Physician** / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a second of the list of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ∏ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) A55 L 1 Yes 2€No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of ertifie

State Registrar 31. Date filed (Month, Day, Year)

30. Name and

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32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

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Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Z Š Physician/ Month 2111 MAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medic. Hone BUINIE Birthplace (State or Foreign Country)
 MT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 - F Months Min. 08-04-1932 Director 220-28-5415 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 XXNo MD Anne Arundel Severn 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8033 Fair Breeze Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 1958 Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Electrician U.S. Government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Anthony G. Ostman Catherine Mary Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Eugene C. Mills, Jr. - son 5802 Maple Terrace, Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1xx Burial 2 ☐ Cremation 3 ☐ Removal from State 06-28-10 Meadowridge Mem. Prk. Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature di Funeral Service Licen-22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, inc., 7250 Wash Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to in reclate cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ Ao 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform SCUCTE 1 Yes 2 No Yes al or Attending Physician: The safter death. Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 →No Other: npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 23 Physicia, X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 28a,b,&d,perME,G905,7/26/2010,WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death a a li Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21<sup>ay</sup> Edward O'Neill 2010 June 6:16 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16001 Bonniebank Terrace Montgomery Darnestown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
May 14, 1970 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours 173-58-9447 40 Pennsylvania Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Tes 2 X No Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16001 Bonniebank Terrace 20874 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Information Technology Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ M. Paul O'Neill Betty Lydek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Domaruk / Wife 16001 Bonniebank Terrace, Darnestown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 23. 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland M01305 20850-2805 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and eath Immediate Cause (Final Physician/ H 9 disease or condition 01 Medical resulting in death) Due to (or s a co equence of): Examiner Sequentially list conditions Examine Due to for as a consequence on. if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No 9 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 ☐ No Hospital Other: 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury Find Park AM ☐ Natural 5 Pending 2 🕅 No Jun 21 2010 1 Yes Accident Investigation Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rusal Route Number of City or Town, State) / 600 / 1500 n n 1 e 500 / 700 / 1500 n n 1 e 500 / 4 4 Homicide determined Home within 24 hours a

To the Funeral C Jer. Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 1000428 2 Jum Aco MMODME 21 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Ira N. Brecher,

M.

32. Registrar

524 Hawkesbury Lane, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>Mo</u>nth Day Year Physician 2010 :07 A sther /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Kano ost, ta altimole 4hu If Under 1 Year | If Unde Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours Min 1 □ M 2 👿 F 08-22-1917 PA 217-20-6946 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "nature!" --- any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD BALTIMORE **SPARKS** Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14550 QUAKERBOTTOM ROAD 21152 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ JAMES DYETT MARTAN CT.ARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD POWELL, JR./SON 14550A QUAKER BOTTOM RD., SPARKS, MD 21152 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State GARRISON FOREST VET 06-29-2010 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC. of Funeral Service License 1701 LAURENS ST., BALTO., MD 21217 Olun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stole 15 disease or condition resulting in death) Due to as a consequence of): FIBE. trial Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans 070 Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical **Examiner** 

Be Completed Certification: To 27. Manner of Death

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

director,

After

after death

Director: /

24 hours af e Funeral Di letely filled in

within 24 hou

To the Fune

completely fi

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 1 Yes 2 No

Natural

2 Accident

3 Suicide

4 Homicide

**JUN 25** 

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 □Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one) and manner stated. 29b. Signature and

| 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ■ Medical Examine® On the basis of examination and/or investigation in my opinion, death accounts to the cause (s) and manner as stated. Medical Examines On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D0060293

29d. Date signed (Month, Day, Year)

RANDAUS TOWN MD 21133

erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address OLD COURT RD

31. Date filed (Month, Year)

AYMED, MD.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William D. Payne III June 24 201<sup>°</sup>0 5:10a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7921 Circle Drive Carroll Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 15 **Funeral**  Birthplace (State or Foreign Country) 1 Ϊ M 2 🗆 F Months Days Hours Min 74 226-42-8040 Director 1936 VA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 27 any injury or other trainment. 10a, State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD Carroll Mt. Airy 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7921 Circle Drive 21771 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married 2 □ No Korea 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) milkman dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William D. Payne Jr. Doris Dodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Joyn, State, Zip Code) 7921 Circle Dr., Mt. Airy, MD 21771 Mrs. Marlyne Payne (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State All County Cremation 6-25-10 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Chiquopaght of triburt P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Chrisic Obstructive disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown 2 No has been signed by the 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 No After this certificate Be B 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by ☐ Homicide determined within 24 hours a

To the Funeral C

completed filled Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only o 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

ddress of person who completed cause of death (Item 23a) (Type

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician John Alfred Parsons June 2010 7:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Abingdon

Vear | If Under 24 Hrs. 3808 Washington Avenue 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) Months 1 XM 2□ F 246-28-2511 1925 Director 85 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location artment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Expriser mast by rottled at 1 ∏Yes 2 XNo Director Maryland Harford Abinadon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3808 Washington Avenue 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ģ Specify 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Engineering Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi and Mental I James Arthur Parsons Tessie Mae Parsons ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lillian Snow Parsons / Wife 3808 Washington Avenue, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 Removal from State permit. Page: Department o Important: If I any injury or once. Bel Air Memorial Gdn. 6/24/2010 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or compliance that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one came on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to for as a consequence disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed Venenta. burial-tran attending physician and Due to (or as a consequence of): Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yarkinson 2 🗆 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

25201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

5701

32. Registrar's Signature

29c. License number

D31295

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Day 2010 20 Phillips 9:15 P. M Senia Ruth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 408 Winslow Drive Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth Days Hours 1 M 2 X Director Yrs 218-26-7145 80 1929 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at ano. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Winslow Drive 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 X Married ☐ Yes 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Earl Thomas Adams Hassie May Mink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Phillips / Spouse 408 Winslow Drive, Bel Air, Maryland, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Air Memorial Gdn: 6/24/2010 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIND Physician/ disease or condition resulting in death) STOS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No 2 -25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 2 No Other: မြ 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 124 hours after deat e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10

Registrar
DHMH 17 Rev 7/2009

State

W. MACPITA./ RD

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Bel AIR MS

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DMUS

32. Registrar's Sgnature

BLENGID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Year June 20, Physician/ 11:55 PM Pezzica Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Jarrettsville Madonna Heritage 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, )
Apr. 19 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 🗆 M 2 🔀 91 Maryland Director 213-12-8686 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Bel Air Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 21015 821 Flintlock Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant Furniture Retail iit. Page 1 and 2 should be filed within artment of Health and Mental Hygiens ortant: If item 27 is marked other thinjury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Josephine (nmn) Kramer Joseph (nmn) Mroczka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 821 Flintlock Drive, Bel Air, Maryland 21015 Ernestine DuBois / Niece Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdm. 6/25/2010 Fallston, Maryland fign fure of Meral SAc icensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ year's Demontdisease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 4 Pregnant a Pregnant at time of death 1 ☐ res ∠ ☐ g ☐ Unknown Hospital or Attending Physician: The law requires that the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? Sicree decibiles 24a. Was an cate has page 2 s performed? 1 🗌 Yes 2 🗆 No this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Prother (Specify) ALF 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5  $\square$  Pending 1 Natural 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: At ampleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 6/2/110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kluesz 5 701 Kenwood 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 20

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Year **Physician** 0200 M John Perry 22,2010 UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisbury Salisbury Rehab Nursing Ctr. S. Social Security Number 6. Sex 7. Age (Inf)rs. last birth 8. Date of Birth (Month, Day Sept 25, Birthplace (State or Foreign (Irf-rs. last birthday If Under 1 Year) 922 **Funeral** Days Min. Months Hours Mary Land 1 ☑ M 2 □ F 87 216-16-7211 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show 1 □Yes 2KNo Salisbury Director Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21804 830 S. Shumaker Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural", or itel 1 Yes 2 No 1942− If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married Specify: white 1 ☐ Yes 2 🔀 No Specify. Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EMT** medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Hayman Rufus Perry ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 830 S. Shumaker Drive; Salisbury, Maryland 21804 Gloria Perry - wife permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation B Removal from State 4 ☑ Donation 5 ☐ Other (Specify) of Euneral Struice Licensee Ronald Wad 22. Name and Address of Facility State Anatomy Board; 655 West Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications by caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on leart failure. List only one care of each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condina n resulting in death) **Physician** geara /Medical Due to (or as a consequence of): Examiner are 02 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse ence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 ŪNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

To the river after death.

To the Funeral Director: Af

Baltimore,

State Registrar 29b. Signature and title of certifier

Villiam H.

31. Date filed (Month, Day,

200

29c. License number

29d. Date signed (Month, Day, Year)

lisbury, MD 21804

and manner stated.

M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 994 Amend Item 25 per me, g904-26/25/2010dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year EARLINE KOGERS JUNE 12:58 PM /Medical 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES BALTIMORE Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days 213-36-1914 **Director** 70 MARVIAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Eventher must be notified at 1 Yes 2 □ No BALTIMORE Director MD 10e. Street and Number 10g. Citizen of What Country? 21217 1802 Funeral U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 🎾 No þ Specify. Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item Many injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL NURSE 12 PRIVATE DULY Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL CLARK MARY WATKINS ည 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) 2/2017 19a. Informant's Name/Relationship (Type. Print) JANET ROGERS / DANGHIER 912 STAMFORD ROAD, BALTIMORE, MARY JAND ace of Disposition (Name of Date 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONA 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State Tematory or other piace)

MORE NATIONAL (25/2010 BALTIMORE, MARY AND

22. Name and Address of Facility The DERRICK C. JONES FIH, B.A. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 4611 PARKHGIS. AVE, BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUBDURAL (TEMATOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 30245 EXTENSIVE SUBARACHNOID Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tra Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Dav 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy Vital 2 No 2 No 1 □Yes 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Medical Certification: To 1**X** Yes 2 → 40 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA oţ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐No

State Registrar

DHMH 17 Rev 1/2001

filled in by

e Funeral I

within 2 To the 1 the

206en

3 🗌 Suicide

29a, Certifier (Check only one)

4 Homicide

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUCHANGCO

MD

3. Registrar's Signature

900

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

23495

28f. Location (Street and Number or Rural Route Number, City or Town, State)

S. CATON AVENUE BALTIMONE MD 2029

29d. Date signed (Month, Day, Year) JUNE 18 2010

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

Physician Medical Examiner  4a. Eacility Name (Into institution, give street and number)  4b. City, Towg, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4d. City, Towg, or Location of Death  4d. City, Towg, or Location of Death  4d. County of D	Inside City Limits  1 Yes 2 No ? S Indian,  te stry		
The client   Town   T	e (State or Foreign and Inside City Limits 11/2 Yes 2 No ? S Indian, te stry		
Funeral Director    Social Security Number   6. Sex   7. Age   (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   03/19/1939   9. Birthplac Country   Maryland   10d.   (Month, Day, Year)   03/19/1939   Maryland   10d.   218 - 36 - 79 53   1   Marital Status   10b. Country   Maryland   N/A   Baltimore   10d.   21231   United States   10d.   21231   United States   10d.   21231   United States   11d.   Marital Status   12d.   Was Decedent Ever in U.S.   Armed Forces of Year or Dates   1   Marital Status   1   Mercedent States   1   Mercedent S	Inside City Limits  11/2 Yes 2 No ? S Indian,  te stry		
Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A  Baltimore  10c. City, Town or Location  Baltimore  10d. Tip Code  10g. Citizen of What Country  10a. Street and Number  2209 Duker Court  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  11. Marital Status  11. Mere Married 2 Married  3 Widowed 4   Divorced  12. Was Decedent Ever in U.S.  12. Was Decedent Ever in U.S.  13. Was Decedents Hispanic Origin? (Specify Yes or No. Il Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American  15. Specify: White, etc.  16. Decedent's Usual Occupation  (Specify only highest grade completed)  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Was Decedents Usual Occupation  (Give kind of work done during most of working life. Do NOT use retired)  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Kind of Business/Indus  16. Mother's Name (First, Middle, Maiden Surname)  16. Kind of Business/Indus  16. Mother's Name (First, Middle, Maiden Surname)  16. Kind of Business/Indus  16. Mother's Name (First, Middle, Maiden Surname)  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Mother's Name (First, Middle, Maiden Surname)  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Mother's Name (First, Middle, Maiden Surname)  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Mother's Name (First, Middle, Maiden Surname)  16. Decedent's Usual Occupation  16. Kind of Business/Indus  16. Decedent's Usual Occupation  16. Mother's Name (First, Middle, Maiden Surname)  18. Mother's Name (First, Middle, Maiden Surname)  18. Land of Decedent's Usual Occupa	Inside City Limits  IN Yes 2 No  Resident No		
10a. State   10b. County   10c. City, How his form of the part o	ty Yes 2 No ? s Indian, te stry  ode) 21231		
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4 Donation 5 Other (Specify)  21. Sig ur of Funeral Service Licensee  22. Name and Address of Facility David J. Weber Funeral Homes P.A.  401 S. Chester Street Baltimore Marylan	21231		
4 Donation 5 Other (Specify)  21. Sig ur of Funeral Service Licensee  22. Name and Address of Facility David J. Weber Funeral Homes P.A.  401 S. Chester Street Baltimore Marylan	21231		
4 Donation 5 Other (Specify)  21. Sig ur of Funeral Service Licensee  22. Name and Address of Facility David J. Weber Funeral Homes P.A.  401 S. Chester Street Baltimore Marylan			
4 Donation 5 Other (Specify)  21. Sig ur of Funeral Service Licensee  22. Name and Address of Facility David J. Weber Funeral Homes P.A.  401 S. Chester Street Baltimore Marylan			
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/Medical resulting in death) Due to (or as a consequence of):			
Examiner  Sequentially list conditions, if any leading to immediate to the conditions of the condition	-		
cause. Enter Underlying Cause (Disease or injury  Following			
Cause (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last			
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d) & g o   Q   autopsy   prior to comp	sy findings available pletion of cause of		
25. Was case referred to medical examiner?  124 Yes  25. Was case referred to medical examiner?  125. Was case referred to medical examiner?  126. Place of Death (Check only one)  127. Manner of Death  282. Date of Injury  283. Date of Injury  284. Date of Injury  285. Time of  286. Place of Death (Check only one)  286. Place of Death (Check only one)			
performed?   death?   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   No   No   No   No   No   No			
Month, Day, Year) Injury p Work?  So to the distribution of the determined of the property of the determined of the property of the determined of the property			
Parking Lot Baltimore, MD			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Date signed (Month, D. 29b. Signature and title of certifier 29c. License number  29a. Date signed (Month, D. 29b. Signature and title of certifier)	ated. the cause(s)		
29d. Date signed (Month, D.	lay, Year)		
D0067859 5/20/10	5/20/10		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
bypyon 1 Tayla 4940 EASTERN AVENUE BALTIMORE MD	71724		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 29d per dr., 8904,0672572010dhb

1- For Amend Items 23aPt1,25,27,29a pr me,8964,0672572610dhb

Certificate of Death

Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 9.19AM QUI/ **Physician** 100 O. trac /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name 'If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2X F Days Yrs 214-83-8920 Director Oct.1, 2008 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a, State 10b. County 10c. City, Town or Location show must be notified at 1 X Yes 2 ☐ No MD N/A Baltimore Director 28a-f 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number ō 21214 USA 6617 Marietta Avenue 23a Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No items 14. Race - American Indian 11. Marital Status Black White etc ortant: if item 27 is marked other than "natural", or itei injury or other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other than Child 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Darchelle Gillespie Tareif Ransom ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darchelle Gillespie/ Mother6617 Marietta Avenue Baltimore, MD 21214 Department of Health a Important: If Item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a, Method of Disposition 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/15/10 Oaklawn Cemetery Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral Home MD 21206 4210 Belair Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhag **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Complications of liver transplant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER death certificate be executed attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live birth 2 - Fetal death in the past 12 months? page 2 should be detached for 4 Pregnant at time of death Month Day Year 1 Yes 2 No P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 🗆 No 3 Probably 4 Unknown 1 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 1 Yes 2 No 2/ certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient Other: 4 Nursing Home 5 Residence 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Division 1X Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and little of certif 29d. Date signed (Month, Day, Year) 29c. License number June 6, 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person cevis 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 2 5 2010 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5&17perFH, G905, 7/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 20 ay 20 ÎÖ Physician/ June 12:10 PM Wayne Ricks Robert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Tracys Landing 6517 Clagett Avenue 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) Funeral Davs Hours Min. Northy Carolina 1 M 2 D F 77 March P2, 1933 <del>348-43-7869</del> Director ecedent 10d. Inside City Limits or 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director Chevy Chase Montgomery Maryland 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20815 Funeral 7415 Ridgewood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes Give Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) University Professor Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any injury or other trainment 17. Father's Name (First, Middle, Last) **Dillon Ricks** Louise Swann ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7415 Ridgewood Avenue, Chevy Chase, Maryland 20815 19a. Informant's Name/Relationship (Type, Print) Patricia Ricks/Wife 20b. Place of Disposition (Name of cemetery crematory or other place)
Crematorium, Inc. June 22, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 ey Funeral Home/ Wisconsin Avenue 21. Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) 6 years **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Unochying Examiner Due to (or as a consequence of): attending physician and for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗔 Probably 4 ื Unknown Benign Prostatic Hypertrophy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 K No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Vacation Home examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28a. Date of injury (Month, Day, Year) funeral 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation Accident completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier D35996 June 21, 2010 M.D. 2730 University Blvd. W#400, Wheaton, Maryland 20902 Name and address of person who come M.D. Burrell, 32. Regis ar's Signature 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5 perFH, C903 5/21/2010 All Copies Are
State of Maryland Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g904,06/25/2010dhb
Registrar
Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 5:45 M ries 05 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Medical N/Aniversity 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1931 Mary Land Days (Month, Day, Year) 1**x** M 2 □ F Months Hours Min. 1055 78 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State within 72 hours after death with the Maryland Director Baltimore 1 ☐ Yes 🏖 ☐ No Cockeysville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21230 14032 Cuba Road 12. Was Decedent Ever in U.S. Armed Forces? 1952 If Yes, Give 1960 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify. marked other than "natural", 3 Widowed 4 Divorced Completed Important: If item 27 is marked other than "natur any injury or other traumatic event, th∍ Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Gemstar Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Truck Driver <u>10th grade</u> <del>Conrete</del> Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elsie James R. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4032 Cuba Road Cockeysville, MD 21030 permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Catherine B. Smith/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Gough U.M. Church Cem. 5/25 Date 0 5/25 10 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cdckeysville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD21215 21. Signature of Fineral Service Linux 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ intra ase or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence or) M APPROVED BY MEDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ing physician and s as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical CERTIFICAT Fax forms the attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, to 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: work? (Month, Day, Year) injury Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1861650 236 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore South 31. Date filed (Month, Day, Year) 82. Registrar's Sign ture State MIN 2520 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Petrus Gerardus Schouten Medical 06/21/2010 2:35 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11213 Powder Horn Dr. Potomac Montgomery Funeral 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 🗆 F Months Days Min. 214-60-0682 83 Hours Director (Month, Day, Year) 06/16/1927 Netherlands Usual Residence of Decedent death with the Maryland 10a. State Director 10c. City, Town or Location 10d. Inside City Limits notified 28a-f MD Montgomery Potomac 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 11213 Powder Horn Dr. 20854 United States items Was Deceus Armed Forces? 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural" Completed 3 Divorced 4 Divorced Specify: White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Embassy of the Elementary/Seconday (0-12) College (1-4 or 5+) the Deputy Comptroller Netherlands event, t Be 17. Father's Name (First, Middle, Last) and Mental Fis marked of 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be other traumatic Wilhelmus Schouten Johanna de Boer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Elisabeth Posner Schouten- Wife 11213 Powder Horn Dr. Potomac MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 permit. Page 1 and Department of I Important: If ite any injury or of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Chesapeake Crematory 106/23/2010 Beltsville, MD 21. Signature of Funeral Section Lip insee 22, Name and Address of Facility 933 Gist Ave.20910 Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) a Cerebrovascular Accident Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions. if any leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or as a nonsequence of) Exami that the death certificate be executed ician and burial-trans Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Mitral Regurgitation Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? pe Division of Vital Records, or Attending Physician: The law requires Dementia Completed 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Gallstones 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Diabetes Mellitus certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ျှ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral to 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar DHMH 17 Rev 7/2009 29b, Signature and title of certifier

Kalman

JUN 2 5 2010

31. Date filed (Month, Day, Year)

Cura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1396 Piccard Dr. Rockville MD 20850

32. Registrar's Signature

29c. License number

D20367

29d. Date signed (Month, Day, Year)

06/22/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 06/20/2010 9:16 A<sup>M</sup> Phyllis Earldean Schwendy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Healthcare Center Gaithersburg Birthplace (State or Foreign Country)
 New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5 Social Security Number 6. Sex **Funeral** 1 □ M 2 🕶 F 09/23/1920 Director 101-14-1834 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan The molfilled at once. 10a. State 10h County 1 ☐ Yes 2 No Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20877 301 Russell Ave. #409 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2 No Specify. δ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl K. Staton Louella Failing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18420 Cape Jasmine Way Gaithersburg MD 20879 <u> Brenda Krueger- Daughter</u> Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 06/21/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 933 Gist Ave. 20910 21. Signature Fineral Sept 5 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) on estive heart Laye **Physician** /Medical Due to (or as a consequence of): Examiner Arteriosclec caquantially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transi Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) signed by the a 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe teas Thretis 1 ☐ Yes 2 1No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending ours after death, leral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Physician: To the Hospital or Attending within 24 hours a

altimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 04115

GAITHERSBURG, MIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June June Physician/ 2010 1:10 A M Schimel Bernice Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery 6. Sex . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 □ M 2**X** F Months Days Hours Min. Nov 26, 1928 81 Director 139-20-5830 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland notified at Director 1 Yes 2 No Montgomery Silver Spring Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 20906 United States 14508 Homecrest Road Apt 418 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Store Legal/Conveni 12 <u>Legal Secretary/Owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bunchez Rosa Isidore Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herndon, Virginia 20171 Janet Platt/daughter 3122 Harrison Hollow Lane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 6/25/2010 4 Donation 5 Other (Specify) Woodbine, Maryland ture of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Bronchogenic Care moma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause) Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : g ☐ Unknown signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed this certificate has death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner's 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

( lucked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Christopher J. Mans, mo

D39793

18111 Poma Philip Dr. Olney, mb 20832

29d. Date signed (Month, Day, Year)

June 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral		Social Security Number     6. Sex	st birthday)	If Under	1 Year Days	If Under 2 Hours		8. Date of Birtl	) Voarl	9. Birt	hplace (State or Foreign				
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	or 28	Director	Maryland Carrol  10e. Street and Number		l	<u>Hampst</u>	ead 10f, Zip	Code				10a Ci	tizen of What Co			
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21215-0036	ırsaf ural", I Exa	eq	3XXWidowed 4 □ Divorced	If Yes, Give Year or Dates.		1	☐ Yes	2 <b>ALA</b> No	Specify:				Specify: Wh	ite		
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anc	ntal File	0	17. Father's Name (First, Middle, Last)	1 · C C							(First, Middle, I	vlaiden .	Surname)			
Maryland	ould to	ľ	Elmer John David Sc 19a. Informant's Name/Relationship (Type					<i>(</i> 2)			y Dice			- 03.07.4		
Σ	2 shell the art trau		Shirley E. Rill (Da											Code) 21074		
ē,	1 and f Hea item other		20a. Method of Disposition	agricer /	20b. Pla	ace of Dispos	sition (Nan	ne of					stead, M			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1XXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Johi	m <sup>etery, crem</sup> n Luth	er M	ther place LIIer	2		e 25,		•			
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Division of	or At after of Direct in by	Certificate:	4 Homicide determined	28e. Place of Inju building, etc		ne, farm, stre						n (Street and Number or Rural Route Number, Town, State)				
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical		r: On the basis of ex	xamination a	and/or investig	oation, in n	noinigo va	death occ	urred at t	he time date an	d place	and due to the ca	ause(s) and manner stated		
	Vithil Comp	~	29b. Signature and title of certifier				29c.	License r	number		2	9d. Dat	e signed (Month,	Day, Year)		
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	K		30. Name and address of person who com													
	8		M. PANSURYA 31. Date filed (Month, Day, Year)			2910	- P	(pro	ک ر	(-+a	whosh	<010	~ ( M	21074		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI Line tale of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Year June 16, Physician/ 11:30 AM Joseph Stephen Sweet Jr. Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1013 Tamworth Road Bel Air 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** (Month, Day, Year May 15 1 X M 2 □ F Maryland Director 63 218-46-9713 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Tes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21015 1013 Tamworth Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1X Yes 2 If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u> Telecommunications Technician</u> Telecommunication 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rita (unk) Grabowski Joseph Stephen Sweet Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1013 Tamworth Road, Bel Air, Maryland 21015 Elizabeth C. Sweet / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Population 5 ☐ Other (Specific) Holly Hill Memorial 6/19/2010 Baltimore, Maryland ation 5 4 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Enter the disease, or complications that caused mock, or heart failure. List only one cause on each line. ease, or complications that caused the death. Do no Immediate Cause (Final disease or condition years Physician/ Medical resulting in death) Due to (or as a consequence of) -1574-) Examiner Sequentially list conditions. Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Pregnant at time of death g 🗌 Unknown g ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page 2 death? 1 🗌 Yes 2 No 25. Was case referred to medical examiner?

1 🖾 Yes 2 🗌 No 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c}\begin{arr မ ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year)

JUNE 16,2010 License numbe 29b. Signatu 756811 who completed cause of death (Item 23a) (Type, Print) 30. Name and address 106 JUS/RAMWWI AN

DHMH 17 Rev 7/2009

State Registrar 32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure AU-Copies Are Legible. amend items 10c, 16a-18 20a-c, 22 per in gould State of Maryland 1 pengrinent of Health and Merial House Beg. No. Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $\mathbf{P}^{\mathsf{M}}$ 15 2010 16:55 Leslie Swartout June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Joseph Medical Center St. Joseph Med 5. Social Security Numberunk Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 ☑ M 2 🗆 F Months Days 214-46-9545 Yrs. 65 Oct 26, 1944 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 1304 Aintree Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces?unk 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 🛣 No If Yes. Give Specify: Completed by 3 Widowed 4 Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation unk

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-unic 5+ Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ant; If Item 27 Is marked other than NASA Contractor 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname Be Leslie R. Swartout Catherine Yuele other traumatic ည Alexander McMullen/attorney 19b Mailing Address (Street and Number or Bural Route Number, City or Town, State Tip Code)
1504 E. Joppa Road, Towson, MD 21286-5911
7601 Osler Drive; Towson, Maryland 21204 Joseph Medical Center Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 ☐ Creme 3 Removal from State inter the disease or heart teil. 4 □ Donation 5 100 1 otate Parkwood Cemetery 7-7-10 Baltimore, Md. 21. Signature of Funeral Service Ronald 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part 1 Enter the disease, it complications that caused the death show or heart failure. List only one cause on each line.

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) **Physician** · Arteriosclerotic Cardiovesch /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of). attending physician for use as the buria Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 21, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) -ar Militello MD Hill Ci. Luthenville, reimb 32. Regist r's Signature State 25 Registrar

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Baltimore, Maryland 21

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Judith Taxlor Month 7:30PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Baltimore Randallstown Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 🗆 M 2 🗆 F 05/29/1953 **Director** MD 219-60-6522 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5600 Pimlico Rd. 21209 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Mortgage Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Ashe Jr. Gretna Nancy Flay Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Fley Edmonds - Daughter 7511 Carroll Ave Takoma Park MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Uniformed Services 4 ■ Donation 5 ☐ Other (Specify) 06/21/2010 Bethesda, MD m00382 933 Gist Ave. 20910 Signature of Funeral Service Lice Se 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring MD Lohun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter orderlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death g Unknown page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 6 Dothersoffithent hospice Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number KajafalneM.D D6057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209. N.S. RajapaKse 2835 Smith Av. MID

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STANE 15 Medical (if not institution, g 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDICAL NIA BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Country). 1 X M 2 - F Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other terms." 10b. 10d. Inside City Limits 10c. City. Town or Location by Funeral Director 1 No Yes 2 □ No TARY/And HIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21207 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes, Give 1 Yes 2 No Specify HMERICA Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DISAble VeteRAX Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 450N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State une 30,2010 Wings ARRISON FORESH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 21224 3405 Franklin St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death this certificate has been signed by the an director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 X 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 24 within 2. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE 10 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Physician/ JOHN WILLIAM TURNER วัติาก 19 2:34 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Months Days Hours Min. (Month, Day, Ye New Jersev Director 1952 220**-**62-8277 Tan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director notified 28a-f 1X Yes 2 ☐ No Maryland Harford Bel Air 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? must be Funeral 21014 205 C. Crocker Dr. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: "natural" 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Frank Turner Dorothea Katherine Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Elisabeth Turner / Spouse <u> 205 C. Crocker Dr., Bel Air,</u>  $MD_{21014}$ Baltimbre, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State Department of Important: If any injury or once. Service Corp. 6-21-10 4 Donation 5 Other (Specify) Towson Maryland 21. Signatur of Funera Service Lio 20 Name and Address of Facility Home, P.A. Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical University of the William Moter Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy death? 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifie XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medicateraminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Countying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and til 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30 Name and add

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 5 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:00 P M 10 Mondson /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Battimos If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days West Virginia Months Min. 1⊠M 2□F Yrs. Dec 30, 89 Director 233-42-1800 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐Yes 2 ☐ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." any Injury or other traumatic events. USA 21218 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No 1942 If Yes, Give Year or Dates: 1944 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Un 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 1 2 engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nanny Helen Grubbs Robert Louis Thompson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Gordon - nephew 8400 Farell Drive; Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 Other (Specify) 22 State Adda to Baltimore Street Director Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e (Final disease or con resulting in death) Physician ementou /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter or Jerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b autopsy perform or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 217110 6 Dother (Specify) Memcry Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier > 7 Isabelle D13657 Tuke 21,2010

State Registrar 31. Date filed (Month, Day, Year)

MISABELLE

MACGRETOR. 700 W- 4
(Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 25 2010 Some S. park

700 W. 40 th STREET,

BALTITIRE 57021211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Angelique 15:12 PM **Physician** 2010 /Medical 4a. Facility Name (If not in stitution, give street and number) 4b. City. Town, or Location of Death 4c. Count of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day Age (In yrs. last birthday) **Funeral** 213-76-646 3 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 → Yes 2 No Director MOYA 10g. Citizen of What Country 10e. Street and Number 10f, Zip-Code 21213 750 Funeral death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced lack Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be and Mental ame! ucas 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cepartment of Health ar. Important: If item 27 is rany injury al 20a. Method of Disposition 20b. Place of Disposition (Na cemetery, crematory or 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Balto. 1701 23a. Part 1. Enter the disease, or complications that cause the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter th ortha Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last EXAMINER Examine Due to (or as a consequence of, WED BY MEDICAL The law requires that the death certificate be executed burial-tran and CERTIFICATION Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) detached by the 9 Unknown of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed 2 page 2 should be 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No Yes certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 2× 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred Certification: (Month, Day Division 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Tes 2 🗌 No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation. within 24 hours 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

Registrar DHMH 17 Rev 1/2001

State

29b

Rosert Hoesel

32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

29c. License number

D67406

29d. Date signed (Month, Day, Year)

une

600 North Wolfe St, Baltimore, MD, 21287

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 010 19963 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald McDuffie Williams Month Day June 19, 2010 Medical Examiner 1825 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2503 Gibbons Avenue Baltimore 5 Social Security Number 7 7. Age (In yrs. last birthday) 5 2 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** Director Months Days May 6,1958 1 M Usual Residence of Decedent 'n 10a. State 10b. County 10c. City, Town or Location
Baltimore 10d. Inside City Limits Maryland 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she vinury or other traumatic event, the Medical Examiner must be notified at once rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Gibbons Avenue 21214 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 2 🔀 No 1 Yes USA 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 Y No specify: Specify Ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 10th grade Janitor Private Industry 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Donald Strickland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Loretta Williams /wife 140 Nunnery Lane Catonsville MD 21228
Date | 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Kurial 2 Cremation 3 Removal from State Trinity Cemetery 6/25/10 4 Donation 5 Other Specify. Dundalk, Maryland 22. Name and Address of Facility.
Chutman-Harris Funeral Home 21. Signature of Funeral Service License Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Narcotic (morphine) intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ned for use as the burial - transit The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED 23a, PII, 27, 28-af, per ME g906 8/11/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Hypertensive atherosclerotic cardiovascular this certificate has been 24a. Was an 24b. Were autopsy findings available disease, cardiomegaly prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene 1 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Director: 1 Yes 2 X No Fd 6/19/10 Fd 6:00 pm 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 2503 Gibbons Ave Baltimore, MD found at residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year)

10-04665 Bruce Winks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

219-52-3556  July Residence of Decedent  Oa. State  Oa. State  10b. County  Maryland  Oa. Street and Number  2318 Tarletor  1. Marital Status  1. Never Married  2. Marrial  3. Widowed  4. Divor  15. Decedent's Education (Specific Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Light Light Catherine  19a. Informant's Name/Relationship  Catherine  10a. Method of Disposition  11bull  12a. Cremation  12a. Signature of Funeral Service Light  23a. Part I. Enter the discase, or failure. List only one cause of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, fany, leading to immediate  Sequentially list conditions, fany, leading to immediate	Winks give street and number all  Sex 7. A  XM 2 F  Timore  Ti	Age (In yrs. la  10c. City, Par  10c. City, Par  2 X No  2 X No  2 X No  5 +)  .fe  20b. Fe  Ar Co  ed the death.	A 6 Yrs.  Town or Location RVIII 6  S. 13. Was If Ye 1  16a. Decedent during moduling  Don  2  10f. Zip Code  2123  Decedent of Fas, specify Cuba  Yes 2 X N  Subsual Occup  St Of working li  Lity M  Address (Str  Dindri  tion (Name of cer place)  Ematio  ame and Address  ame and Address  Address (Str  Dindri	4 Hispanic Originan, Mexican, Mexican, Give k fe. DO NOT control of the control o	Death  24Hrs. Min.  Min.  N? ( Spece Puerto Riverse retirected a l d i per or Rur r c l e	June 21, 20  B. Date of Birth(  Sept. 1  10g  Iffy Yes or Nocan, etc.)  k done  irst, Middle, Ma  ne E.  al Route Number  Apt. Foate  25-10	MM/DD/YYYY  8,196  Citizen of Will  J. S. A.  14. Race Whit  Specify:  6b. Kind of Builder Surname Winks er, City or Tow  3, Balt  20c. Location	9. Birth Foreign 3 Court hat Count hat Count e, etc.  Whi usiness/in t C e) c i mo c city or T	ntry) Marylar  10d. Inside City Limits 1  Yes 2  No ry?  an Indian, Black,  te dustry  ompany  Zip Code) 21234 re, Maryla	
a. Facility Name (if not institution, Good Samaritan Hospit 5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 10b. County Maryland Bal 10b. County Maryland Bal 10c. Street and Number 12318 Tarletor 1. Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 2 Never Married 2 Married	give street and number all  Sex 7. A  Timore  Timore  Lane, Ap  12. Was Deceded Armed Force: 1	Age (In yrs. la  10c. City, Par  10c. City, Par  2 X No  2 X No  2 X No  5 +)  .fe  20b. Fe  Ar Co  ed the death.	A 6 Yrs.  Town or Location RVIII 6  S. 13. Was If Ye 1  16a. Decedent during moduling  Baltimore  If Under 1 Ye Months Date on December 2123  December 2 X N Secretary Secretary Secretary Secretary Market Market Secretary Market S	4 Hispanic Originan, Mexican, Mexican, Give k fe. DO NOT control of the control o	24Hrs. Min.  Nin.	June 21, 20  B. Date of Birth(  Sept. 1  10g  Iffy Yes or Nocan, etc.)  k done  irst, Middle, Ma  ne E.  al Route Number  Apt. Foate  25-10	MM/DD/YYYY  8,196  Citizen of Will  J. S. A.  14. Race White Specify:  6b. Kind of Burname Winks  er, City or Tow  3, Balt  20c. Location	9. Birth Foreign 3 Cours hat Count hat Count e, etc. Whi usiness/In t C e) S wn, State, cimo city or T	place (State or  ntry) Marylar  10d. Inside City Limits 1 Yes 2 X No  ry?  an Indian, Black,  te dustry  Ompany  Zip Code) 21234  re, Maryla	
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or condition resulting in death)  Sequentially list conditions,  if any, leading to immediate		usive	a a red i a st							Between Onset and Death
f any, leading to immediate				asculai	. uisea	136				
f any, leading to immediate	b									
if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	d									
XUNPENDED	AMENDED 27	, PII,	per ME	G905 7	/2/10	TT				
F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outo	come or pregi	nancy —					23d. Date o		av Year
past 12 months?	1 Live birth	at time of de			BEctopic	pregnanc	У	Month	Da	ay real
Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										
Part II. Other significant conditio	ns contributing to de	eath but not re	esulting in the u	nderlying cause	e given in Par	t L	23e. Did toba	acco use cont		he cause of death?
Chronic alco	hol abuse						1 Yes	2 No 3	Proba	ably 4 🗸 Unknown
									Were autoprior to co	opsy findings available empletion of cause of
		· · · · · · · · · · · · · · · · · · ·								s 2 No
25. Was case referred to medical				26.Pla	ice of Death (	Check on				
examiner?	Hospital: 1 Inpa	atient 2 🗸	ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5 R	esidence 6	Other:	
27. Manner of Death	28a. Date of I	Injury v. Year)	28b. Time of Ir	njury 28c. Ir	njury at Work	? 2	8d. Describe ho	w injury occur	red	
Torigin	ng	,,,		1	Yes 2	No				
	28a Place of	f Injury - At h	ome, farm, stree	et, factory, office	e building, etc	2. 2			per or Rur	al Route Number, City
4 Homicide	10,000)					!_				
Charleson   Celulying Filly	vsician: To the best of	f my knowled	ge, death occur	red at the time,	date and pla	ce, and d	ue to the cause(	s) and manne	er as state	ed.
	and manner state	examination a ed.	ind/or investigat			Julied at t				
29b. Signature and title of certifier		<b>\</b>						-		ui, Day, rear)
11/1/	11 2/4	$\rightarrow$		0.0	J. IVI. ⊑.			Julie ZZ, Z	.010	
Mlm Bra	ne l, MH									
30. Name and address of person w	who completed cause of Assistant Medic			enn Street,	Raltimore	MDO	1201			
27 29 (0)	5. Was case referred to medical examiner?  1  Yes 2 No  7. Manner of Death 1  Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could determ 4 Homicide 9a. Certifier 1 Certifying Physics	examiner?  1 V Yes 2 No Hospital: 1 Inpa  7. Manner of Death 1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  9a. Certifier 1 Certifying Physician: To the best of early manner state and manner state.	5. Was case referred to medical examiner?  1	5. Was case referred to medical examiner?  1	5. Was case referred to medical examiner?  1  Yes 2 No  1  Astural 5 Pending Investigation  3  Suicide 6 Could not be determined (Specify)  9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, check only 2 Medical Examiner; On the basis of examination and/or investigation, in my opin and manner stated.  26. Place of Injury  28b. Time of Injury  28c. Ir (Specify)  28e. Place of Injury - At home, farm, street, factory, office (Specify)  29c. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, only 2 Medical Examiner; On the basis of examination and/or investigation, in my opin and manner stated.  29c. Lice  O. (O. Name and address of person who completed cause of death (Item 23a)	5. Was case referred to medical examiner?  1	5. Was case referred to medical examiner?  1	24a. Was an autopsy perform 1 Yes 2  5. Was case referred to medical examiner?  1 Yes 2 No  7. Manner of Death 1 X Natural 5 Pending Investigation 3 Sucide 6 Could not be determined (Specify)  28a. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)  28c. Injury at Work?  28d. Describe how 1 Yes 2 No  28d.	24a. Was an autopsy performed? 1 Ves 2 No  No  Natural 5 Pending Investigation Builder Gould not be determined Generated to Medical Examiner:  Could not be determined Generated to Medical Examiner:  To the best of my knowledge, death occurred at the time, date and place, and manner stated.  25c. Place of Death (Check only one)  26c. Place of Death (Check only one)  26c. Place of Death (Check only one)  26c. Place of Death (Check only one)  26c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occur 1 Yes 2 No  28d. Describe how injury occur 28d. Location (Street and Numbor Town, State)  28d. Describe how injury occur 28d. Location (Street and Numbor Town, State)  28d. Describe how injury occur 3 Suicide 6 Could not be determined (Specify)  28d. Describe how injury occur 3 Sec. Place of Injury 1 Place of Injury 28c. Injury at Work?  28d. Describe how injury occur 3 Sec. Place of Injury 28c. Injury at Work?  28d. Describe how injury occur 3 Sec. Place of Injury 28c. Injury at Work?  28d. Describe how injury occur 4 Homicide  28d. Describe how injury occur 3 Occurred at the time, date and place, and due to the cause(s) and manner of Death (Check only one)  28d. Describe how injury occur 4 Homicide (Specify)  28d. Describe how injury occur 4 Homicide (Specify)  28d. Describe how injury occur 4 Injury 28c. Injury at Work? 4 Oction 4 Describe how injury occur 5 Occurred at the time, date and place, and due to the cause(s) and manner of Death (Check only one)  28d. Describe how injury occur	24a. Was an autopsy performed? 1

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			For State Registrar		Ola	ite of iv	iai yiai i		tificate of l			/ierriai i i	Reg. N	7.31	0	19965
	Physicia		1. Decedent's Name EVELYN GE									2. Date of D Month	D	ay	Year	3. Time of Death
-	Medic Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of										1,30 (			
	Funeral		5. Social Security N	6. Sex	7. Ac	,	ast birthday)	Raus If Under 1 Year	If Unde	er 24 Hrs.	8. Date of B	irth	None	9. Birthp	place (State or Foreign	
	Director		212-34-6398 Usual Residence of		1 □ M 2	XX <sup>F</sup> 10	3	Yrs.	Months Days	Hours	Min.	March <sup>th</sup> 2	", <sup>v</sup> 1907 Mar			y Yand
	ryland -f shov ied at	ctor	10a. State	10b. County				, Town or Lo	cation						1	0d. Inside City Limits
	the Ma or 28a se notif	Funeral Director	Maryland 10e. Street and Nun	None nber			Гватт	imore	10f. Zip Code					Citizen of W	hat Cour	1 XXYes 2 No
•	ath with ems 23, must l	unera	4516 St Geo	orges Av		Decedent	Ever in LLS	s. 13. v	21212	lispanic C	rigin? (Sp	ecify Yes or No		SA 14. Race	Amorio	on Indian
9800	ırs after de ural", or ite I Examiner	Completed by F	1 Never Marr		ried 1 If Ye	led Forces Yes 2 2 es, Give r or Dates.	cesty If Yes, specify Cuban, Mexican, Pu 2 1 Yes XX No Specify:					Rican, etc.)	etc. <b>hite</b>			
215-(	an "nati Medica	mple	15. Decedent's Education (Specify only highest grade completed)				E.\\	(Give I	lent's Usual Occup kind of work done O NOT use retired)	during ma	ost of work	ing	16b. Kind of Business Industry			dustry
121	d withir dygiene ther th	Be Co	Elementary/Seconday (0-12) College (1-12)  17. Father's Name (First, Middle, Last)				5+)	Home	maker			(5)	Own Hame			
/lanc	d be file Mental H arked or rtic ever	TOE	John Miller		-ast)							e (First, Middle Cooper	e, Maider	n Surname)		
, Maryland 21215-0036	nd 2 should salth and N n 27 is mo		19a. Informant's Na Ronald A W	me/Relations ICKS	hip (Type, Print	Son	1	19b. Mailir 4016 C	ng Address (Street Ioverland l	<sup>and Num</sup> Orive	ber or Rure <b>Phoen</b> :	ix, Mary	er, City o	or Town, Sta 21131	ate, Zip C	Code)
nore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	20a. Method of Disp 1 XXBurial 2		3 🗆 Remova	I from State	, C	emetery, cren	sition (Name of natory or other plac <b>Cemetery</b>	ce)		Date 26,2010	1	Location - 0 esville	-	
Baltimore,			2 innature of Fur	-	licente	Ven	aki		. Name and Addre		ility Mit	-	ete	Id Fund	erall	Hame Inc
	hysician/		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or conditio	t failure. List o Final	only one cause	on each lin	e.		er the mode of dyir	ıg, such a	as cardiac (	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Second Property of the Parks	Medical Examiner		resulting in death)			ue to (or as			5145							11 0175
		niner	Sequentially list co if any, leading to im cause. Enter United	mediate tying	D	Due to (or as a consequence of):										
	e executed ian and urial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Co. RENAL FAILURE  Due to (or as a consequence of):										+			
68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	ledica	d										$\pm$			
. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ■ 9 ☐ Unknown	norths?	1 4	es, outcome Live Birth Pregnant a Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (spec <i>ify)</i>	су				23d. Date Mon		ery Day Year
ls, P.O.			Part II. Other signif						nderlying cause gi							ne cause of death?
Records,	<b>hysician</b> : The law requires his certificate has been sig I director, page 2 should b	Completed by	DEMEN					NEMI		ENS	HON		opsy ormed?	pr de	ior to co	osy findings available impletion of cause of
ital	sician: certific rector,	Be	25. Was case referre examiner?  1  Yes 2	ed to medical	Hospital:				26. Pi	or.	eath (Chec	k only one)				
of Vital	ding Phy th. After this funeral d	ate: To	27. Manner of Death			Date of inju	iry	ER/Outpatien 28b. Time of injury	28c. Injur	4 <u>L</u> J y at		ing Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
Division	Attendi er death. ector; A by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investi 6 Could determ	not be 28e.				M 1 🗆 Yes 2 🗆 No					et and Number or Rural Route Number,		
Div	pital or A ours after eral Direc filled in by		i .			building, et						City or To				
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2	Medical E	xaminer: On t	he basis of e	xamination	and/or invest	occured at the time igation, in my opinion leath occurred at the	on, death	occurred a	the time, date	and plac	e, and due t	to the cau	use(s) and manner stated.
	With		29b. Signature and	title of certifle	AMIT	BHIS	se.	MBB	29c. Licens		000			ate signed		Oay, Year) - 2010
	4		30. Name and addre	SHISE		ause of c	eath (Item	23a) (Type, P	of BAC	TIM	ORE	- , M	> ~	212	15	
	Star Registra		31. Date filed (Month	5 2010	Gener	32. Registr	ars Signat	Parke	,							
DHM	1H 17 Rev 7/20				1	7 /	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Alfred Brower Warren June 23 2010 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 703 Grantwood Road Middle River Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/25/1942 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M M 2 □ F Months Days Hours Mary Land 214-40-1867 67 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director Maryland Baltimore Middle River 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Grantwood Road 21220 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Representative Retail Pages 1 and 2 should be filed vent of Health and Mental Hygie int; if item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be partment of Health and Menta portant; If Item 27 is marked Injury or other traumatic ev Clyde Emerson Warren Helen Eva Jaworski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Warren (Wife) 703 Grantwood Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If if any Injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 06/25/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility nski Funeral Home, P.A. 21. Sign ure of Funeral Service, Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm rate Cause (Final dis se or condition re ulting in death) STROKE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Diabetes milleta 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate durin leg ulcers - cellulitis performe 1 □Yes 2 ■No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 🗆 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Ronald

ATTANOSIO MO 31. Date filed (Month, Day, Year) 32. Registar's Signature

Romard attarasio MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-28097

Philadelphia Rd. Suite 108 Balt, Md. 21237.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25, per me. 9952 6-2-14 SM State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wallace Eugene Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Gieneral Baltimore Jary/and NA Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. (Month, Day, Year) 08-11-35 Country) Director 74 SC 50-54-475 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at one. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21217 1654 W. North Avenue 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: Specify: American 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
7th Grade College (1-4 or 5+) Self-employed Tire salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Annie Mae Wallace Wallace, Sr. Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8632 Willow Oak Road Parkville, MD 21234 Edith Blackwell-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Randallstown, 06-28-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. Street Baltimore,MD 21217 22. Name and Address of Facility 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Ph, sician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of): ulmonar To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 CERTIFICATION IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Year 1 Yes 2 5 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6/22/10 land 31. Date filed (Month, Day, Year) State JUN 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bethany Lynn Youkers 1514 June 2010 Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital of Baltimore Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 28 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months Days Hours 23 Director 195-66-2471 Sept Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is smarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethany Youkers MD Baltimore Baltimore 1 🗆 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2105 Southland Road 21207 USA 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Was Decedo...
Armed Forces?

1 Yes 2X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married Specify: white 1 Yes 2 XNo Specify: Baltimore, Maryland 21215-003 If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) day care assistant child care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alan Youkers Marla Kay Kaltenbach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Southland Rd., Baltimore, MD 21207 19a. Informant's Name/Relationship (Type, Print) Mr. James A. Youkers (father) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State All County Cremation 1 Burial 2 XCremation 3 Removal from State 6-24-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Venous Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam burial-trar resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Box 68760 IF FEMALE attendin 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Hospital or Attending Physician: The law requires that the death 0 in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗆 Yes 2XNo 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 ☐ Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1.XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 X Natural work? 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) June 21, 2010 D0066614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tennifer L Berkely, MD Sinci Hospital of Baltimore

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Amend Items 23 april ,25 per me, 8904,06729/261th and 20 ental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE  $13^{\text{Day}}$ 2010 LEONARD ZIMMERMAN 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOVE HOUSE WESTMINSTER CARROLL 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months Hours Min 0270171929 **Director** 109-20-5198 81 NY Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examination 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD **HOWARD** 1 🗌 Yes 2 🙀 No WOODSTOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2115 GANTON GREEN #206 21163 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE 3 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ACTUARY BENEFIT CONSULTING Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ FRED ZIMMERMAN FANNY KARP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHODA ZIMMERMAN/WIFE 2115 GANTON GREEN #206, WOODSTOCK, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06/15/2010 1 KBurial 2 Cremation 3 K Removal from State SKY LAWN MEMORIAL PK | 06/14/2010 | SAN MATEO, CA 4 Donation 5 Other (Specify) gnatu of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause Approximate Interval Betweer Wk shock, or heart failure. List only one cause on each line Aspiration Immediate Cause (Final Ph\_sician/ disease or condition 17 retivious I Jennes Medical resulting in death) Due to (or as a consequence of): Advanced Alzheimer' s Dementia Years 🔾 Examiner Asove Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to A as a consequence of): BY MEDICAL EXAMINER attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): CERTIFICATION Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident Suicide 5 Pending Investigation
Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death/occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the past of examination and or prestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Fractioner: To the best of physician accurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practioner: 29b. Signature and title of certifie 1737944 June 13th 201

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

Prop

JUN 25 201

cause of death (Item 23a) (Type, Print)

32. R gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar		artment o					510	10070
			Registrar  1. Decedent's Name (First, Middle	o (act)			inicate	n Deat		2. Date of Dea	Reg. No.	0 10	3. Time of Death
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-	/Medic		4a. Facility Name (If not institution	Haking			4b. City, Tow	or Locatio	on of Death	6		ounty of Death	
	Examin	er	Golden Living (		iniber)				nster			Frederi	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Und	der 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
н	Director		432-68-8683	1 □ M 2 🛣 F	73	Yrs.	Months Da	ys Hour	rs Min.	(Month, Da March			intry) st Virginia
	ם _		Usual Residence of Decedent										10d. Inside City Limits
	srylar show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo							1 ☐ Yes 2 No
	8a-f	Director	MD Freder	rick				inste	er		10 - 00:	en of What Cou	
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	item item	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed F	edent Ever in U orces?	1.5.	If Yes, specify (	Cuban, Mexi	ican, Puerto	ecify Yes or No Rican, etc.)		Black, White,	
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yla	should be f and Mental   s marked of umatic eve	은	Jesse Cecil Wha							h Ann G			
Maryland 21215-0036			19a. Informant's Name/Relations		`	1				al Route Numb			
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altimore,	Pages nent of int: If its iry or o		1 ☐ Burial 2 ⊊ Fremation	3 ☐ Removal from			natory or other		1	8-2010		•	
<u>=</u>	permit. Pages Department of Important: If it any injury or o	1	4 □ Donation 5 □ Other (S		AL.		Cremato						cal Home at
Ba Ba	Depi Impo	9	pre 13.	Bloha	um								MD 21075
п			23a. Part 1 Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not en	ter the mode of	dying, such	n as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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Ŋ,	/Medical Examiner		resulting in death)	Due t	(or as a consec	que nce of):							,
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	execu n and al-tra	zaı	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):							w yes
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89	tificat ig phy as the	Physician/Medical										-	
Вох	eath certific attending p for use as	N/UE	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		☐ Ectopic pregr	nanev			23	3d. Date of deli	
B	deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specif					Month	Day Year
<u>Р</u>	at the de	Phy	9 Unknown							22a Did t	00000 110	o contributo to	the cause of death?
ŝ	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditi	ons contributing to t	death but not res	sulting in the u	nderlying cause	e given in Pa	arti.		Yes 2		
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Records,	has has ge 2 s	du								24a. Was auto		prior to death?	topsy findings available completion of cause of
a	sician: The certificate rector, pag		05 M							1 □Yes	2 <b>AN</b> 0	1 🗆 Yes	2 🗆 No
5	Physician: The lav this certificate has al director, page 2 s	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	T EB/Outpotio	nt 2 DOA	Othor		h (Check only o		Other (Case	-15.1
o	y Phy er this eral d	Ĕ	27. Mapner of Death	28a. Date	e of Injury	28b. Time o		Injury at Work?		ome 5 Resi 28d. Describe			ліу)
<u>ö</u>	nding F ath. r: After e funer	ațio	1 Anatural 5 ☐ Pendir 2 ☐ Accident investi	ig .	nth, Day, Year)	Injury	М	vvork? 1 ∐Yes 2	2 □No				
Division of Vital	or Attending Physician: frer death. Director: After this certifica in by the funeral director, g	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 200. Flat	e of Injury - At h	nome, farm, st lifv)	reet, factory, off	ice		28f. Location ( City or To		Number or Ru	ral Route Number,
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	To the Hospital or Attent within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1  Certifyin (Check only one) 2 Medical	ng Physician: To th Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or i	th occurred at t nvestigation, in	he time, dat my opinion,	te and place, death occur	, and due to the red at the time,	date and	and manner as place, and due	s stated. to the cause(s)
	Vithir Vomp	Me	29b. Signature and title of certific	h			_	cense numb				signed (Monti	
			John W	( midd	ben,	4D	D	254	43		6/	16/2	010
			30. Name and address of person	who completed car	use of death (Ite		Print)				7	11.	
			31. Date filed (Month, Day, Year)	Miggre	Registrar's Sign		88 Po.	de la la	(d, L	NESTM	HENI	a, MJ	21157
H	Sta Registr		JUN 282010	h. sz.	I logistial's olgh								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 19, Day 2010 Year Physician/ 3:00 Ам Adkins D. Pau1 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 1924 Maxwell Avenue Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Feb 24, Year) 944 1 XM 2 - F Sprague, WV 232-66-0754 66 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Baltimore 1 🗆 Yes 2 🔀 No M 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 21222 USA 1924 Maxwell Avenue 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Auto Body Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thelma Starr Floyd Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1527 North Point Rd. Baltimore, MD 21219 John Paul Adkins Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Beckley, WV 6 - 22 - 104 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 22. Name and Address of Facility Rose & Quesenberry Funeral Home ture of Funeral Service Licenses 1901 S. Kanawha St Beckley, WV 25801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGES disease or condition resulting in death) VEA/ Medical Due to (or as a consequence of) Examiner NIERIOR Se, uentially list conditions if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 OBTIQUETINS SLEEP APNEA 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION has page 2 CITRONIC OBSTRUCTIVE PULMONAR certificate 1 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ¥ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural work? 1 ☐ Yes 2 ☐ No 5 Pending e Hospital or Attendi 24 hours after death. e Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 23, 2010 234 041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 601 LOCIT RAVEN BLUD. BALTIMONE MI M 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Server

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST. PM RI CH AR D 2010 12:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A SAMARITAN HOSPITAL BALTIMORE 100 D If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 84 Yrs. 9. Birthplace (State or Foreign **Funeral** Days 214-22-1555 1 ☑ M 2 ☐ F November 10, 1925 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State rai", or items 23a or 28a-f show Examiner must be notified at Maryland Baltimore 1 Yes 2 □ No Director 10f. Zip Code 21206 10g. Citizen of What Country? 10e. Street and Number 4607 Valley View Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: þ Specify: 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Allied Chemical Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ind Mental I Arthur August Anna Unknown other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1526 Neighbors Avenue Baltimore Maryland 21237 19a. Informant's Name/Relationship (Type. Print) Health em 27 is Robert J. August/Son of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dispartment o Important: If i any injury or 0 Most Holy Redeemer 6/29/10 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Economic Sold Baltimore Maryland 21214 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SIPSIS **Physician** disease or condition resulting in death) /Medical OBSTRUCTIVE PULMONARY
1015 EASE 24 Hour Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 2 🗆 No 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ∐Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is a provided and place. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00 58913 MD JUNE 26 2010. Maniso Sain.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOVLEVADD MANISHA BAHL, MD BALTIMORE, MARYLAND 21239

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month A. AMEDORE 15:32 PM JUNE OHN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE JOHNS HOPKINS BAYLIEW MEDICAL CENTE N/A 8. Date of Birth (Month, Day, Year) Aug • 4, 1926 If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☒ M 2 ☐ F Mary Yand **Director** 220-12-7772 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director MD Dunda1k 1 🗆 Yes 2 🖺 No Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States Funeral 8211 Shore Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tavern Business Owner 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Marie Fiammi Joseph Amedore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4419 Todd Point Lane Sparrows Pt., MD 21219 Mr. Mark A. Amedore (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔣 Burial 2 🗌 Cremation 3 🗋 Removal from State Baltimore, Maryland cem.6/24/201D Donation 5 Other (Specify) Most Holy Redeemer 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland . Signa ure of Funeral Service Licensee Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. 23a, Part 1. Approximate shock Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ CARDIO PULMONARY ARREST IHOUR disease or condition Medical resulting in death) Due to (or as a consequence of Examiner PNEUMONIA DAYS Sequentially list conditions Due to for as a consequence of if any leading to immedicause. Enter Underlying Examin Cause (Disease or iinjury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy law requires that the death in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed within 24 hours after death.

To the Funeral Director: After this certificate I Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 w rector. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 👿 No 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

DHMH 17 Rev 7/2009

Registra

State

29b. Signature and title

KIT LU

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940

AVENUE

EASTERN

32. Registre s Sign

29c. License number

RES - 000

BALTIMORE

29d. Date signed (Month, Day, Year)

21224

MD

JUNE 20, 2010

10-04524	
Andrea Arnold	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

Andrea Amold	1- For State Registrar  Certificate of Death Reg. No.	
Physician/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year	
Medical Examiner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	5720 Everhart Place Fort Washington Prince George's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Nonths Days Hours Min.  Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday) Yrs.  If Under 1 Year If Under 24Hrs. Nonths Days Hours Min.  O(0/02/1993) Country)  O(0/02/1993)	
and show any nce.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin	
n the Maryland 3a or 28a-f sh otified at one	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  20744	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Instit: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes 2 No specify: 18. Race - American Indian, Black, White, etc.	
ours aft	or Dates:	
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after do  bepartment of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or  njury or other traumatic event, the Medical Examiner m  To Be Completed by Ft.	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)  Student	
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21; hould b and Men is mar stric eve	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 s lealth au tem 27 traum	Patrice Y. HEFLIN /MOTHER 5720 EVERhart Pl., FT. Wash. MD., 20149  20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Menal Hygiene Important: If item 27 is marked other tinjury or other traumarite event, the Metaliury or other traumarite event eve	1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify:  CHESQPEAKE CREMATORY 62312010 Belt-SVILLE, MD	
Balti permit. Departi Import injury	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  420 H ST. N. E.  B.K. HENRY FUNERAL HOME WASH.DC. 20002	-
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease a Cardiac arrhythmia   Death	
Examiner	or condition resulting in death)  Due to (or as a consequence of):	$\neg$
Je Je	Sequentially list conditions, if arry, leading to limited atterminate to the control of the cont	-
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.O. Bc s that the dee gned by the a e detached fo by Phys		_
ords, P.C	Chronic renal disease  1 Yes 2 V No 3 Probably 4 Unknow 1 24a. Was an 1 24b. Were autopsy findings availa	
Records,   The law requires ficate has been sig page 2 should be Completed	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	
ital Recional: The secrificate rector, page	25. Was case referred to medical 26. Place of Death (Check only one)	$\exists$
f Vita Physicia er this ca ral direc	1 Yes 2 No liner: Scene	_
vision of ' or Attending Ph filter death. in by the funeral iffication: T	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   1 Yes 2 No	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deach ledical Certification: To Be Completed by P	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route Number, Control of Town, State)	ity
To the Hospital within 24 hours To the Euneral completely filler		
F 7 F 8	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  June 15, 2010	
	30. Name and address of person who completed cause of death (Item 23a)	
	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	ATTIM SET STREET SET SEED AS A CO. SERVING TO THE SET SET SET SET SET SET SET SET SET SE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2010 CLEOPATRA ALEXANDER BRUTUS 19 6:30P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 5, 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Guyana 1 🗆 M 2 🗶 F Months Days Hours Director 220-06-0585 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anones. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Fredrick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 800 Motter Avenue, Apt. 516 21701 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Beldoza Rollins Frederick McGarrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504Gerry Court, Waldorf, Maryland 20602 <u> Alexis Brown</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Thc.6-28-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final <sup>e</sup>nysiciau disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of,: Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atter Day Year 5 Other (specify) Month Pregnant at time of death Part II. **Other significant conditions** cont<u>rib</u>uting to death but not resu<u>lti</u>ng in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2,000 1 Yes 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XVo 1 Yes ER/Outpatient 3 DOA မ 1 Xinpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29c. License number MOD 64146 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick a 0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 282010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** unty of Death Ti 1501 19 ocial Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 **K** F Months Hours Min. Texas 62 585<del>-</del>12-8077 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director must be notified Sykesville Carroll Maryland 1 Yes 2 X No 10f. Zip Code 5 10e. Street and Number 10g, Citizen of What Country? 23a Funeral U.S.A. 21784 5761 Oakland Road items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Medical Examiner 1 Yes 2XX No If Yes, Give Year or Dates. 5 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Office Manager Law traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be i Jane Evelyn Johnston Harvey Edwin Gilliland and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5761 Cakland Road Sykesville, Maryland 21784 John Blais (Husband) item 27 other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 6-23-2010 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices Witzke runeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a Part 1. Enter the diecase of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 40 1 Yes Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Dea 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 21,2010 rson who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar amend 7,15,1 per DR. g907 Sertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Baby Girl Bryant 2010 22:46 p M 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Grove ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE SHADY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 KF Days Hours 08 NONE 05 2010 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shor edical Examiner must be notified at 1 Yes 2 □ No ROCKVILLE, MARYLAND MONTGOMERY Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ROAD 2085 BALTIMORE USA 2018 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRYAN Item 27 Is marked other traumatic ev BREANNA ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE ROAD #J44. Rockville MD MOTHER 20851 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-23-10 Alexandria, VA 22. Name and Address of Facility Metropolitan Funeral Service 21. Signature of Funeral Service Libensee 5517 Vine Street, Alexandria, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final XTREME PREMATURITY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of perform death? 1 □ Yes certificate 2 No 21 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of after death, I Director: After to d in by the funera 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 1004+ MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 20850 MD 9901 MEDICAL CENTER DRIVE ROCKVILLE FREEDMAN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 282010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:07 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number ocation of Death 4c. County of Death TMUL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Min. Month Day 09/23/ **Director** 84 213-20-3024 NY Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21201 Charles Street Apt. 807 524 N. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Navy Civilian Worker Be snould be file th and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kelly **Brydges** Catharine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 so nt of Health a : If item 27 i 870 Seneca Park, Baltimore, MD 21220 Annice Ripperger, Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens Of Faith 06/26/2010 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co ce of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 🗆 Yes 2 🗀 No 3 🗖 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7399 who completed cause of death (Item 23a) (Type, Print) BALTMORE, MD A 8T. PtUL MD 301 31. Date filed (Month, Day 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene
		1 - State Registrar Certificate of Death Reg. No.2   1 9979
Physici	an/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  7' 08 PM
Med	ical	Tools Tools
Exami	ner	4a. Facility Name (if not institution, give street and number)  By Himore Washington Medical Center 4b. City, Town, or Location of Death  4c. County of Death  Anne Arundel
Funera		5 Social Security Number 6 Say 7 Age (In yrs last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Righthage (State or Foreign
Directo		220-72-1378  1 DM 2 F 74 Yrs. Months Days Hours Min. (Month, Day, Year) Country) April 01,1936 Mason, S. Korea
D ow	٦.	Usual Residence of Decedent  10a. State
ırylanı a-f sh fied a	cto	Maryland Anne Arundel Co. Odenton
he Ma or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with t	Funeral	302 Gatehouse Lane Unit C 21113 United States
death items	ᇤ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ING 21213-UU36  Filed within 72 hours after death with the Maryland Ital Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	gp	1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Korean
215-0036 in 72 hours after te. han "natural", o	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Z15 n 72 t e. lan "n	Ę	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Vgiene ygiene t, the		12 N/A Small Business Owner Small Business
Maryland 27 2 should be filed with th and Mental Hygien 27 is marked other traumatic event, th	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Minung Coop Too
re, Maryla t and 2 should by t Health and Mer item 27 is mark other traumatic		Jong Hak Bae  Myung Soon Joo  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
		Mr. Jae Sung Bae (Son) 1318 W. Seminary Ave. Lutherville, Maryland21093
Ore,		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Page ment of anticle uny or		1   Burial 2   XCremation 3   Removal from State 4   Donation 5   Other (Specify)   Cremation Services, Inc.   June 26,2010   (Harford County)   Forest Hill, Maryland
<b>Baltimore,</b> permit. Page 1 and Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Center, P.A.
		1 2325 York Road Timonium, Maryland 21093-2215
		shork, of heart failurg. List only one cause on each line.  Interval Between Onset and Death Onset and Death
Physician Medica	_	disease or condition resulting in death)  Due to (or as a consequence of):
Examine		Gestrointestinal homorrhese 2 hours
	Examiner	Sequentially list conditions, If any, leading to immediate  Dug to (or as a consequence of).
cuted nd ransit	Xam	Cause (Disease or linjury that initiated events c
'60 ate be executed physician and the burial-transit	ä E	resulting in death) Last Due to (or as a consequence of):
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Kecords, P.O.  The law requires that the ate has been signed by the page 2 should be detach	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
rdS equire	eted	
eco e law i has b	Completed	autopsy prior to completion of cause of
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Of ng Ph ter thi	Ę:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of vork? 28c. Injury at work? 28d. Describe how injury occurred
ION tendir leath. tor: Af the fu	ifica	Accident Investigation M 1 Yes 2 No
DIVISION OF VITAL RECORDS, ral or Attending Physician: The law requires s after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be an in by the funeral director.	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Spital nours neral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is	Medical	(Check only one)  (Check one)  (Check only one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Check one)  (Ch
To the complete complete to th		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Valle Kaklov, M.V. D68240 June 29, 2010
		Jackin Kaklov, MD.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Or Clov 301 Hospital Drive, Glen Burnie, MD 21061  31. Date filed (Month, Day, Year)  32. Registral Signature
	ate	31. Date filed (Month, Day, Year) 32. Registral Signature.
Regist		31. Date filed (Month, Day, Year)  32. Registrate Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JUNE 01:18 PM Physician/ 2010 Elizabeth Bertha Beohmer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAINT JUSEPH MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 22, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number New Jersey Funeral Months Hours 1 □ M 2 X F 85 1925 Director 151-14-0663 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 ☐ Yes 2 🖔 No Baltimore Glen Arm Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 11630 Glen Arm Rd 21057 U.S.A. Apt. L16 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 If Yes Give 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Glen L. Martin Co. Billing Clerk 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) and Mental I မ Mary Norton Jay Norton Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11630 Glen Arm Rd. Apt L16, Glen Arm, MD 21057 item 27 Elmer Beohmer (Spouse) or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel
Bel – Air 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 27, Forest Hill, Maryland 2010 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Parkville Signature of Funeral Service Licensee 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MULTI ORGAN SYSTEM FAILURE Physician/ Medical resulting in death) VALVE REPLACEMENT **Examiner** Sequentially list conditions, sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in dotto). REGURGITATION SEVERE MITRAL anding physician and use as the bunal-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Por 5 Other (specify) Pregnant at time of death signed by the at the detached for 9 Unknown 9 Unknow Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been signed by 2 should by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an r this certificate has performe 1 🗌 Yes 2 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: After Natural Accident 5 Pending 1 Yes 2 No M Investigation within 24 hours after death

To the Funeral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, 29b. Signature and title of c 3 7 26002 (Item 23a) (Type, Print) who completed cause of dea 30. Name and address of pe OSLER DRIVE 21204 TOWSON 7601 JOHN H. EXALER 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State 2820 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Ramsey Blair JUNE 05:55 AM Medical 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JUSEPH MEDICAL CENTER TOWSON 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 20, 1957 **Funeral** 9. Birthplace (State or Foreign 1 XM 2 I F Months Days Hours Min. 212-70-0820 Lakewood, Ohio Director 52 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Cockeysville 1 🗌 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 23a Funeral 1035 Misty Lynn Circle Apt.A 21030 items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Wildowed 4 Divorced Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Ray Perrsinger Elementary/Seconday (0-12) College (1-4 or 5+ Photography 04 <u>Photographer</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Benton Blair Elnora Lane Gunsallus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marcie L. Levendusky(Sister) 3203 Wellington Way Baldwin, Maryland 21013 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford Co.) June 28,2010 1 

Burial 2 

Cremation 3 

Removal from State Evans Funeral Chapel and 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services.Inc. ForestHill, Maryland any in Signature of Funeral Service Licensee Cair, Sr. P22 Name and Address of Facilities Funeral & Cremation Center, P.A. 2325 York Road <u>Timonium, Maryland</u> 21093—2215 Jeffrrey) Enter the disease of 23a. Part 1. Enter the disea shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIAC TRANSPLANT Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X s after death.

| Director: After this certificate 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier соmpleted (Check 2 — Medical Examiner: On the basis or examination and/or investigation, in the position, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COURTNEY

31. Date filed (Month, Day,

ROSENTHAL

32. Registrar's Signature

D64300

7601 OSLER DRIVE

24,2010

MARYLAND

TOWSON

21234

10-04574

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Judith Ann Cooper 1 - For State Certificate of Death Reg. No Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0013 hrs June 17, 2010 Medical Examiner Judith Ann Cooper 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Director Country) Maryland 2**X** F 1 M 67 Yrs 19 194 Jan. 215-40-6730 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location uny 1 Yes 2 No Show 23a or 28a-f shov Maryland Washington permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" not team 17 is marked other than "natural" Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 16910 Warbler Court 21740 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2X No 3 Widowed 4 X Divorced If Yes, Give Year Yes 2x No specify: Specify: White ۾ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than " Baltimore, MD 21215-0036 12 Clerk Arts&Crafts Store 18.Mother's Name (First, Middle, Maiden Surnar 17. Father's Name (First, Middle, Last) Ernest Francis Oehm æ traumatic event, Ethel Elizabeth Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 5805Melville Road, Sykesville, Maryland 21784 e of Disposition (Name of cemetery, Date 20c. Location - City of Town, State Rosemarie K. Hofmann nt of Health ant: If item 2 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Ardent Cremation, Ihc.6-26-10 Hanover, Maryl<u>and</u> Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Signature of Funeral Service Licensee

22. Name and Address of Facility

Marzullo Funeral chapel 121

A

16009 Harford Road, Baltimore, Maryland 2121

Part I. Enter the disease for completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart proximate Interval nichal **Physician** Between Onset and failure. List only one cause on each line /Wedical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine rause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Month Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. δ 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of has b performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No page 26.Place of Death (Check only one 25. Was case referred to medical æ examiner? Other<sub>4</sub> Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 V Natural n 24 hours after death. 1 Yes 2 No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 [ To the Fun completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. June 17, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EMMA Medical give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OWSOR If Under 24 Hrs. If Under 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Months Hours Min Director 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director BALTIMORE 1 Tes 2 No WOODLAWN ö 10e. Street and Number 10g. Citizen of What Country? 21207 U.S.A. LENBERN 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 N No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🕱 No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) STATE USTODIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BARNHAR Page 1 and 2 should be UPTON Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/26/7 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) njury or 30/2010 OWINGS Mills MARULANS 22. Name and Address of Facility The DERRICK C. SONES FIH, PA 21. Signature of Funeral Service L BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complications that weed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dercarbi Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to or as a consequence of): requires that the death certificate be executed ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) Day Year ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy performed? Yes 2 N 2 🗆 No 1 \sum Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) n 24 hours atter uccom. After the Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2  $\square$  No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Marie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year DOROTHY DORRIS CLINARD JUNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 24,1920 Country)
Tennessee 1 🗆 M 2 😾 F Days Hours Min. Director 89 408-22-6930 Sep. Usual Residence of Decede 28a-f shov 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Jefferson Frederick MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21755 6626 Stable View Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exa Specify: n res, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Banking Bank Teller traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Myrtle Hackney Smith Dorris Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 6626 Stable View Court, Jefferson, MD 21755 <u>Karen Rushing</u> - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Jun.26,2010 Springfield, TN Elmwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Robertson County Funeral Home one 2201 Memorial Blvd., Springfield, TN 37172 23a. Part . Errer the disease, or complications that caused the death. Do not ender the mode of dying, erlock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conse quence of Exami that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2, No Day 5 Other (specify) Pregnant at time of death signed by the aid be detached Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy 1 ☐ Yes 2 ☐ No certificate Yes 2. N 25. Was case referred 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident work? 5 Pending s after death.
I Director: Aft
d in by the fur 2 🗆 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funeral Direct completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 2010

Registrar

State

who completed cause of death (Item 23a) (Type, Print

SON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \_ State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2010 Columbus Craft 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore City 5020 Wright Avenue 8. Date of Birth
(Month, Day, Year)
Jan. 20,1922 Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Min Country) Kentucky Director 88 403-22-5916 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director N/A MD Baltimore City 1 A Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 Funeral 5020 Wright Avenue United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give WWII "natural" 3 ₩ Widowed 4 □ Divorced White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry marked other than matic event, the Me Elementary/Seconday (0-12) 6 Years College (1-4 or 5+) Steel Industry Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ of Health and Mental item 27 is marked or other traumatic e Reuben Craft Mary Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 (Son) 224 Whitaker Ave. North East, Maryland Mr. Allen Craft 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place)
dns. of Faith Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. 6/25/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of eral Serv 22. Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METAS 27210 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to or as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical spital or Attending Physician: The law requires that the death certificate be vour after death.

Leral Director. After this certificate has been signed by the attending physicia filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie tho completed cause of death (Item 23a) (Type, Print) Philadelphia Rd Ste314 Baltomo 2123)

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State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Cer	tificate of De	ath	, ,	Reg.	No.	
Physici Medical Exam		1. Decedent's Name (First, Middle	Durell, Cartw	right		1	Date of Death Month Da une 21, 201	ay Year	3. Time of Death 0308 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospita			y, Town, or Location timore	of Death		4c. County of	
Funeral			6. Sex 7. Age (In yrs. Ia	//////////////////////////////////////	Birthplace (State or				
Director		Z12-9Y-2808 Usual Residence of Decedent	1 <b>∑</b> M 2□F	30 Yrs. Mo	nths Days Hour	s Min.	uly 18	1979	Foreign Country) Mary and
any		10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
Maryland 28a-f show d at once.	ō	Mary land N/,	4 B.	altimore	2				1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	, C1 1		Zip Code			Citizen of Wha	
vith the s 23a o e notifi		11. Marital Status	12. Was Decedent Ever in U.S		1224 edent of Hispanic Ori	gin? / Specifi	Vac or No		States  American Indian, Black.
5-0036 led within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Mar		If Yes, spe	ecify Cuban, Mexican  2 No specify:	i, Puerto Rica	an, etc.)	White,	
ours af atural samin	d by		or Dates: ify only highest grade completed)	16a Decedent's Usu	al Occupation (Give	kind of work	done 16	b. Kind of Busi	
5-0036 led within 72 hours Hygiene. other than "natur:	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		vorking life. DO NOT	use retired)			
-003 I withi giene. ther the	J L	17. Father's Name (First, Middle, L	aet)	Labore		r's Namo /Fire	st. Middle. Maid	acto	49
	Be C	James Car 19a. Informant's Name/Relationshi							
	To		p (Type, Print )	19b. Mailing Addre	Ss (Street and Num	nber or Rural	Route Number	City or Town,	State, Zip Code)
e, MC 1 and 2 sh Health ar item 27		20a. Method of Disposition	kson-G. Mother  20b. P	lace of Disposition (N	Bouldin	J+ K	Palto.	, MD	2/224
of H i		1 K Burial 2 Cremation	3 Removal from State I	rematory or other plac	<i>(</i> 0)				
Baltimo permit. Pag Department Important: injury or ot		4 Dopation 5 Other Spe 21. Signature of Funeral Service L	icensee // /	int Zion (	ad Addrona of English				nove, MD
Balt permit. Depart Impor injury		Calvin d.	omplications that caused the death. I	270 F	red hilton	PESS	Balto	L SERI	11CE, PA
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause or	omplications that caused the death. In each line.	Do not enter the mod	e of dying, such as c	ardiac or resp	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunshot Wound  Due to (or as a consequence of):						Death
		Sequentially list conditions,	b	·					
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):	:					
sit sait	Examiner	(Disease or injury that trituated events resulting in death) Last	Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED	d. X AMENDED ,,			<del></del>			
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687 certific ding p	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal deat	-	pregnancy		Month	Day Year
Box 68 e death certifi the attending ed for use as	ysic	1 Yes 2 No 9 Unkno		th 5 Other (Sp	ecify)				
P.O. Box 68 es that the death certification by the attending or detached for use as		Part II. Other significant condition	ns contributing to death but not res	sulting in the underlying	ng cause given in Pa	rt I.			ite to the cause of death?
S, P.C luires that an signed Id be deta	ed by								Probably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed		<del></del>				24a. Was an autopsy	pric	re autopsy findings available or to completion of cause of
tal Rec	S	25.44				1	المتما		vith? Yes 2 No
/ital sician: is certif lirector,	m	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 🗸	R/Outpatient 3	26.Place of Death (		ne 5 Resi	dence 6	Other
n of \ing Phy	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 2	28b. Time of Injury	28c. Injury at Work?	? 28d.	Describe how i		
ttendi death.	atio	Natural 5 Pendin 2 Accident Investig	9 1 '	0231 hrs	1 Yes 2 ✓	No Subj	ject shot		
Division of Vital tal or Attending Physician rs after death. Is all Director: After this certiled in by the funeral director	Certification:	3 Suicide 6 Could r	not be 28e. Place of Injury - At hom		y, office building, etc		or Town, State)		or Rural Route Number, City
Di Hospital 4 hours a Tumeral I		29a Cortifies	ined (Specify) Local Street sician: To the best of my knowledge		o time data and pla		Block North E		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) 1 Certifying Physical Exami	ner: On the basis of examination and and manner stated.	d/or investigation, in n	ny opinion, death occ	ce, and due to curred at the t	time, date and p	and manner as place, and due	to the cause(s)
F3E8	N N	29b. Signature and title of certifier	I constitution ordinated.	29	9c. License number		290	l. Date signed	(Month, Day, Year)
		Cheol	Hallan	,	O.C.M.E.		Ju	ne 21, 201	0
$\phi$			no completed cause of death (Item 23 stant Medical Examiner 1	<sup>3a)</sup> 11 Penn Street,	Baltimore, MD	21201			
		31. Date filed (Month, Day, Year)	32. Fegistrar's Signature						
Regist	હો	JUN 282	UIU person p	· Marine					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2Day **Physician** 2010 10:50 PM Louise Pearl Cavagnaro June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/ARoland Park Place Baltimore 8. Date of Birth (Month, Day, Year) Jan. 23, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Director 570-07-4594 90 1920 Oregon Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th. Street 21211 U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hyglene.
unt: If Item 27 Is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner mi Black, White, etc. 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Hospital 5+ years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be California Ida Corrosso Cavagnaro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8112 SW 5th. Ave. Portland, OR 97219 James Cavagnaro (nephew) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 6-26-10 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MRRWA Immediate Cause (Final davanced dementa Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Early of January that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760,≲ Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be rector, page 2 s autopsy performed death? 1 ☐ Yes 2 □ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Mann of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D13657 Vule 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7. ISBELLE TACHREAN, 830W-40 H STREET, BALTIMORE, 79 21211 32. Registrars Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis Cudworth Medical June 10:05 PM 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) March 16. 9. Birthplace (State or Foreign Months Days Min. Hours Director Country) 231-14-4940 86 Yrs. North March 1924 Carolina Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Parkville or 28a-f Maryland Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 8820 Walther Blvd. Apt. 2516 21234 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important, If item 27 is marked other than any injury or other traumoting. Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Towing Company 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vance Levanco Cudworth Ina Midgett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Cudworth (Son) Glen Gate Ct. Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of June 26, Page 1 a permit. Page 1 and Department of F 20c. Location - City or Town, State Wanchese 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cudworth Cemetery 2010 North Carolina 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Crematicn Services 8800 Harford Rd. Parkville, MD 21234 Hacu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bilitu 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walther Blud. Batto. 31. Date filed (Month, Day, Year, State JUN 282010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Amend Items Registrar	State of M. 23aPt1,2	aryland / Depa <b>per me g</b> Cer	artment of H 104,06/25/ tificate of D	P <b>2010alib</b> Peath	Mental Hyg	giene Reg. No.	0	19989
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	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or			4c. County		
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	Funeral Director			<b>X</b> M2□F	61 Yrs.	Months Days	Hours Min.	7/22/13	948	Morga	anton, NC
	M N	,	Usual Residence of Decedent		10c. City, Town or Lo	anti-n		· · · · · · · · · · · · · · · · · · ·		10	Od. Inside City Limits
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	with th	əral	4911 Colonel Add	icon Place	3	20772	)		United :		
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21215-0036	lied within 72 hours after death with the Maryland I Hygiene other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 5	o+)						
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587	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				00.1.0		
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on c	nding ath. : After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Da	ny, Year) injury	work		200. Boodings in	on injury cood		
Division of Vital Records,	· Attel er deg ector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	be 29a Place of Ini	ury - At home, farm, str	eet, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	Check 2 ☐ Medical Exam	niner: On the basis of $\epsilon$	f my knowledge, death examination and/or inves	tigation, in my opinic	on, death occurred	at the time, date a	nd place, and du	ie to the cau	use(s) and manner stated.
	To the within 2 To the comple	ž	only one) 3 _ Certifying Nur 29b. Signature and title of certifier	nse Practioner To the	best of my knowledge.	29c. License			29d. Date signe		
	F 3 F 5		· Polymila				91750 (F	1	JUNE 2,		
			30. Name and address of person who	completed cause of c	death (Item 23a) (Type, I	Print)					
			ROBERT M. KAISER,	M.D., VA	MC 50 IRVI	IG STREET	NW, WAS	HINGTON,	DC_2042	2/688	
	Stat Registra		31. Date filed (Month, Day, Year) JUN 2 5 20	32 Registr	ar's Signature	what			·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 3:45 25,  $P^{\mathsf{M}}$ Arsarilla June Johanna Dawson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1014 Fuselage Avenue Middle River If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/13/1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours West Virginia 90 **Director** 217 40 6764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show ?] is marked other than "natural", or ftems 23a or 28a-f show treumatic event, it is Wedlea Examinar in the multified at 1 ☐ Yes 2 ☐ No Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21220 1014 Fuselage Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify Specify: þ 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home t 2 should be filed with and Mental Hygier 7 is marked other th 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Anderson Fannie Fetty ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1100 Fuselage Avenue Middle River Md 21220 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n eny Injury or other treun Ruth Dawson (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Holly Hill Mem Gardens 6/29/2010 Baltimore Co. Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex Maryland 21221 art 1. Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedite/ause (Final disease or condition resulting in death) **Physician** 21mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed physician and s the burial-trans Due to (or as a consequence of) certificate be Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy certificate 1 □Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending n 24 hours after death.

le Funerei Director: Af
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title 9

AHT

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIVANANDA

32. Registrar's Signature

DHMH 17 Rev 1/2001

within 2

Box 68760.

P.0.

Division of Vital Records,

1124

29c. License number

male

Ave

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elizabeth Mary Duvall June 26 2010 27 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours Director 126/1980 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 No 10g, Citizen of What Country? Funeral items 23a 21157 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?.
1 ☐ Yes 2 🗙 No Black, White, etc. 1 Never Married 2 Married ò by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည pe Jahlonski William permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30 /2010 6 Denation 5 Other (Specify) Funeral Service Licensee Fletcher 22. Name and Address of Facility Westminster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metustasis immediate Cause (Final Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a construence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balfumore O PWALA MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Howard Evers, Jr. George June Physician/ 2010 Day 19 1:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Johns Hopkins Bayview Medical Ctr. Dunda1k 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 □ F **Funeral** Days March 25, 1947 Hours Mary land 63 Director 218-46-5113 Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Dunda1k MD Baltimore 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21222 United States 7428 Manchester Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2X Married 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: Yes. Give Specify: White Year or Dates. Vietnam "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel Co. Permit Inspector 12 Years traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ၉ Blanche Gerlack George Howard Evers, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Forest Hill, MD 21050 132 German Manor Road Robert William Evers (Son) f Health aitem 27 i Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hill Cop Service Corp. 6/23/2010 20c. Location - City or Town, State 20a. Method of Disposition Page 1 ; 1 ☐ Burial 2 本 Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) da-Ruck Fulleral Home of Dundalk, Dundalk, MD 21222 21. Signat of F ner Service Lice Dundalk, MD 7922 Wise Ave not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1. Enter the disease, or complications that caused the death. D Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -HROMC PULMONARY DISEAS Physician/ UBSTRUCTIVE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATHEROSCLEROSIS 1⁴☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of ADRTIC ANEURYSM 24a. Was an has autopsy performed HYPERTENSON 1 ☐ Yes 2 🗶 No After this certificate Hospital or Attending Physician: ' 24 hours after death. Funeral Director: After this certific 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License numbe 29d. Date signed (Month 2010 D33457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dundalk, Maryland 21222 207 Wise Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 282010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1055 AM Physician/ LIAN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year) Country) Virginia 1 □ M 2 🖾 Min 230-28-8680 83 arch **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State Director 1 Yes 2 No Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21113 1345 Farrara Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces 2 No 1 Never Married 2 Married Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 No White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) N.A.S.A. Transportation Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Saphrona Maxine Osborne မ Arthur Daniel Fleenor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Odenton, MD 21113 514 Camelot Court Ronnie Gray - Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Big Stone Gap, VA 6-30-2010 Glencoe Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licenses Name and Address of Facility Holding Funeral Home P.O. Drawer H Big Stone Gap, VA Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between nset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner UCar Sequentially list conditions Examine Due to for as a consequence of, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate h 26. Place of Death (Check only one, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be examiner? Other: 2 300 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Dooth Certificate: injury Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office determined 4 Homicide building, etc. (Specify) Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

Name and address of person who completed cause

32. Reg

the

rar's Signature

29d. Date signed (Month, Day, Year)

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	3		For State Registrar		aryland		artment of I tificate of I	Health and Death	Mental Hy	giene Reg. No	ning	19994	
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21215-0036	rs after o ural", or Examin	ed by	1 ☐ Never Married 2XXXMarried 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Dates.	No		Yes 2XXNo		or liberi, ctc.,		Black, White Specify:	White	
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, Maryland	id 2 shousalth and n 27 is mer traum		19a. Informant's Name/Relationship Mrs. Shirley Fo		e)			and Number or Ru ven Court					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 3 4 🗋 Donation 5 🗎 Other (Spe		ce	metery, crem	sition (Name of atory or other place of Jest	us Cem.6/	Date 25/2010	1	ocation - City of $0$	r Town, State Maryland	
Balti	permit. F Departm Importa any inju		21. Signature of Juneral Service Lice			Ži.		sset Facility a1		Dun	dalk, I	Inc. 21222	_
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused	the death.						y Lana	Approximate	_
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3-3	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
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687	eath certificate b attending physic for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	elivery	
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed that A hours after death.  The Hours all Director, After this certificate has been signed by the attending physician and the Funeral Director, Refer this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Medic	in the past 12 months? 1  Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other (specify)	су			Month	Day Year	
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ouc	nding ath. r: Afte re fune	icat	1 Natural 5 Pending 2 Accident Investigati	(Month, Day	(, Year)	injury	work	Yes 2 No	Edd. Booking 1	iow injur	y occurred		
Division of Vital Records,	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At hom c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox			ıral Route Number,	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director, After completed filled in by the funer.	Medical	(Check 2 D Medical Example (Check 2 December		xamination a	and/or investi	gation, in my opinio	on, death occurred a	at the time, date a	and place	, and due to the	cause(s) and manner state	d.
	To the within To the comple	Σ	only one) Certifying Nu 29b. Si Mature and title of certifier	rse Practioner: To the	best of my l	knowledge, d	eath occurred at th		ice, and due to th		s) and manner as te signed (Mont		-
			Vellissa G	was	CAN	P	KI	2597	3	J	une	23,2010	
+			30 Name and address of person who	completed calls of d	eath (Item 2	23a) (Type, Pr	int) N. CH	TARLES "	ST. BR	HJI	MORE.	MO 21204	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) JUN 28 2010	32. Registra	ır's Signatu	re							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:00 P 2010 Mima June Frazier June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium Baltimore Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Months Hours Min 216-34-4315 Director Dec. North Carolina Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🖾 No MD Harford Havre De Grace 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? 23a 3946 Loch Leven Drive United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ð 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Years Years Homemaker <u>Own Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental H item 27 is marked of ပ Gibbs Garland Ella Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s.
Department of Health a
Important: If item 27 is
any injury or and Dawna Trainor (Daughter) 1003 West Wind Court Towson, Maryland 21204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 6/25/2010 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIOMYOPATHY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Day Pregnant at time of death 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 X No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Division Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 2010 of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

JACKIE JONES,

CRNP

00:9

2010

FRAZIER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **June** 2010 MILDRED ASSUNTA FARRELL 24. 4:55P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Baltimore 401 Cedarcroft Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XX Days Hours Jahuar 9°12°1913 MarvTand 97 215-10-7132 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1**XX** Yes 2 ☐ No Baltimore Maryl and None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 401 Cedarcrodt Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XXNo Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced "natural" Year or Dates Medica 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Parochial School Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Angelina Bankard Page 1 and 2 should be Addison Eugene Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J Mercier PR 220 West Meadowland Lane Sterling, Virginia 20164 other 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Dulaney Valley Mem Gardens June 28,2010 Timonium, Maryland 21093 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTROINTESTINAL disease or condition resulting in death) DMYS Medical Due to (or as a consequence of) Examiner SEPSIS DAYS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached t g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LARGE CELL LYMPHOMA OF THE THYROLD, CORONARY 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? METERY DISEASE TYPE 2 DIABETES, HYPOTITY ROIDISM 24a. Was an performed' this certificate 1 Yes 2 No 2 X N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \begin{array}{c} \subsetext{Residence} \) 6 \( \supseteq \text{Other (Specify)} \) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ottricia Rensall MD 6 25 2010 MD D27209 LUPITERVILLE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA A. SAVADEL, M.D. SUITE 200 MD 21093 10755 FALLS ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

IUN 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Manyland / Department of Health and Mental Hygiene Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min 94 9/12/1915 PA Director 193-07-8871 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10h County 10d. Inside City Limits 10a. State Director 1 Yes 2 No Strabane Straban Township PΑ 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 15363 228 Alexander Ave. United States 2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Exminer mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify. White 3xxWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of PA Road Supervisor 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ပ Barbara Konarzeska Frank Fisher 1 and 2 should b of Health and Mer item 27 is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2439 Braddock Rd. Mt. Airy, MD 21771 Brenda Cox (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's Cem 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 6/15/2010 Canonsburg, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd, Winfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ntracran emound a Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): CERTIFICATI attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? ō Month Day Year 1 Yes 2 9 Unknown the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate I 2 No Yes 2 LA 1 Tes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: n 24 hours after deam. he Funeral Director: After this ce moleted filled in by the funeral dire ၉ 1 Dimpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Watural 5 Pending 1 Tes 2 🗌 No 2 Accider
3 Suicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 To the I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malea (no Drive, Westminita MD 21157

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 5 201

Kaney

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G904, 6/28/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23,2010 Vincent J. Griffin 11:15P M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 5305 Salima Street Clinton 8. Date of Birth (Month, Day, Year) Nov. 15, 1 6. Sex 1 XM 2 ☐ F If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 562-40-4545 **Director** 934 New York Usual Residence of Decedent it of Health and Mental Hyglene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medi-al Examiner must be notified at. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🛣 No Maryland PrinceGeorge' Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 5305 Salima Street U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 X Married Yes 2 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Year or Dates. 57-180 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Air Force NCO-Security 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rose McQuad <u>Unknown</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5305Salima Street,Clinton,Maryland 20735 Mrs. Helen Griffin/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) ArdentCremation, Inc.6-26-10 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009Harford Road, Baltimore, Maryland21214 michall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Airway Obstruction Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year ed by the a detached f 2 🗌 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death,

To the Funeral Director. After this certificate has been si,
completed filled in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 🔀 Naturai 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 70102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Largo, MD 20774 9200 Basil Court Ivan Zama 31. Date filed (Month, Day, Year) State UN 282010 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 215AM Jun 2010 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) towar NUVSING Calumbia Home en 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1**™** M 2□ F Pennsylvania 164-32-2282 70 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Hughestown Luzerne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18640 U.S.A. 12 Renfer Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disable 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Gerrity James Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Woodbine, Maryland 21797 Sandra Gardner (Wife) 3015 Woodbine Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-23-2010 Marriottsville, MD Crestlawn Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Witzke Funeral Homes,
5555 Twin Knolls Road Inc. Columbia, MD 21045

**Physician** /Medic Examin

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f ehow edical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s eny injury or other treumstic event, the Medical Evantural must

Baltimore, Maryland 21215-0036

Director

Funeral

Be Completed by

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s efter death.

or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760,

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	al Certification; To Be Completed by Physician/Medical Examine	L
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	23a. Part1. Eyer the disease, or com shock, by heart failure. List only	plications that caused the death. Do not enter to one gauge on each line.	ne mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition	a cardiomyo	14081						
	resulting in death)	Due to (or as a consequence of):	100	200	Cusar				
<u>.</u>	Sequentially list conditions	b. COVONGV9 and Due to (or as a consequence of):	b. Covonavy avtery disease						
nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a consequence or).							
Examiner	that initiated events resulting in death) Last	C Due to (or as a consequence of):							
lical	•	d							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy her ( <i>specify</i> )	23d	I. Date of delivery Month Day Year				
	Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?				
ed by	stucke			1 ☐ Yes 2 ☐ N	No 3 Probably 4 Horiknown				
ompleted				24a. Was an 2	4b. Were autopsy findings available prior to completion of cause of				
E O				performed?	death? 1 ☐ Yes 2 ☐ No				
e D	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)					
0	1 Yes 20 No	Hospital: 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4 Nursing Hom	e 5 Residence 6	Other (Specify)				
atlon:	27. Manner of Death 1 ANatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?  M 1   Yes 2   No	8d. Describe how injury or	ccurred				
Certification;	3 Suicide 6 Could not b 4 Homicide determined		factory, office 21	Bf. Location (Street and N City or Town, State)	lumber or Rural Route Number,				
edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, as igation, in my opinion, death occurred	nd due to the cause(s) and d at the time, date and pla	d manner as stated. ace, and due to the cause(s)				
ž	29b. Signature/and title of certifier	1	29c. License number	29d. Date s	igned (Month, Day, Year)				
	· Kaylon	MD	1941617	Jun	19,2010				

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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within 24 hours e To the Funerel C completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Day Year Physician 2010 1:15 P.M June 26, Bruce Gardner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X**CXM 2□ F 89 25, 1920 North Carolina Director <u> 214-16-1331</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Heelih and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show usy or other than the Resolution must be retified at ury or other traumatic event, the Resolute transition and the standard or other traumatic event, the Resolute transition and the standard or other traumatic event, the Resolute transition and the standard or other traumatic event, the Resolute transition and the standard or other transitions are standard or other transitions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Funeral Director Hampstead Maryland Carroll og. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21074 of America 1211 N. Main Street, Unit #205 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Parks Ford 6th Auto Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rena Hill Dewey Gardner ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 19a. Informant's Name/Relationship (Type. Print) 1211 North Main Street, Unit #205, Hampstead, MD Department of Heelth Important: If item 27 any Injury or other to once. Beulah Gardner (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Manchester, Maryland New Lutheran Cem. 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Lice 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ovaestwe **Physician** 14cox /Medical Due to (or as a donsequence of): **Examiner** Hortz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 1 ☐ Yes 2 ☑ No certificate 1 □Yes 2 □ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou To the Funer completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
June 28 2 29b. Signature and title of certifier 29c. License number D 52035 2010

State Registrar DHMH 17 Rev 1/2001

DINU CHACKO Stoner 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 28 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Avenue

MO2110

Westmins 7a